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Expectations, Experiences and Plans of Internationally Recruited Nurses in the UK: a Case Study in a NHS Acute Trust in London



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Thesis submitted in partial fulfilment of the requirements of
the University of London for the Degree of Doctor of Public
Health


London School of Hygiene and Tropical Medicine
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London, United Kingdom

June 2007



Statement of Own Work

I have read and understood the School's definition of plagiarism and cheating given in the Research Degrees Handbook. I declare that this thesis is my own work, and that I have acknowledged all results and quotations from the published or unpublished work of other people.

Signed:..........

Date: August 12nd 2007.....

Full name:..... ALVARO ALONSO-GARBAYO (please print clearly)

To the memory of my father who died some weeks before the submission of this thesis. His last words to me were of encouragement and support to finish my doctorate. His memory and my love for him have been the engine and the energy to complete it.

Abstract

In the UK, international recruitment is one of the strategies adopted to tackle the shortage of nurses. It is predicted that the UK will continue relying on internationally recruited nurses (IRNs) in the future. There is high attrition among both national and overseas nurses. While factors determining the turnover of British nurses are generally understood, there is not much evidence about overseas staff.

Literature suggests that factors involved in the decision to emigrate and experiences during recruitment are essential in the development of professional and personal expectations. The extent to which expectations are met is related to job satisfaction and retention. This research aims to improve understanding about the interface between IRNs' expectations, initial experiences and turnover.

The study uses a qualitative approach, asking IRNs from India and the Philippines and using analysis of their narratives to generate data about their expectations and experiences. The first group comprised 6 Indian nurses, who were interviewed three times over eight months since their arrival in the UK, and some of their managers and mentors. The second and third groups comprised Filipina nurses recruited from two cohorts, 6 nurses recruited one and a half years before and 9 nurses recruited four years before.

Findings validate results from other studies about the motivation to emigrate. Motives are often, but not exclusively, economic. Indian nurses come with their families to improve their lives in the UK while Filipino nurses come to help their families back home. Professional and economic expectations are often not met. There are important professional disparities between their countries and the UK. Nurses perceived that there was not enough institutional support for professional and cultural adaptation. Often their experience and skills are neither recognized nor valued. Isolation, frustration and consequently low satisfaction were identified in most of the nurses what is known to be related to turnover.

Acknowledgments

First I would like to express my gratitude and appreciation to my Supervisor Professor Gill Walt, for her untiringly support, inspiration and expert advise. Her generous approach, her patience and her flexibility with the supervision of the three elements of my DrPH have once again been, not only a source of academic learning but also a great human experience. Without your support in some difficult moments during these last four and a half years it would have been very difficult to complete my degree. Thank you Gill. My appreciation goes also to my Associate Supervisor Dr Jill Maben for her great commitment; even when after having left the school she continued providing me with her very appreciated support. Your perfectionism and your invaluable advice from your nursing perspective have helped me in keeping my research on track. Thank you Jill. To Dr Judy Green for your expert advise. Your dedication and availability have greatly helped me through the process but most important have taught me a lesson about professionalism. Thank you Judy.

My gratitude also goes to Dr Javier Martinez. His advice was seminal for the identification and further focussing of my research topic. Thank you to Professor Anne Marie Rafferty for having helped me during the first steps of this research in narrowing the topic and supporting me in finding an appropriate research site. Professor Maureen McIntosh for having provided feedback about my preliminary results and also for her recommendations about key literature on nursing in the Philippines. Thank you to the managers of the Trust where the data collection was undertaken. Very special appreciation goes to the staff in the Recruitment and Retention Department for their dedication and availability. My appreciation to Caroline for her support with IT issues.

My fellow students and friends that have contributed to this research with their views. I will name here those that I remember but this appreciation goes also to those that I do not recall at this moment. Thank you Gregorio, Magda, Alberto, Blanca, Manuel, Cesar, Marian, Arantza, Paco, Thanasis, Helena, Andreia, Brenda, Giuliano, Leslie, Mary, Molly, Jaquie, Cathy, Megan, Anahi, Sumathi, Sonali and Menahksi.

I would like to thank all the nurses that took part in this study. Their generosity and their willingness to share with me their experiences has been the foundations on which

this study was built. I hope it will contribute to improve their experience in return for their contribution. Also to my family and particularly to my father who did not live to see his dream of coming to London for my graduation accomplished. Finally I am greatly indebted to Douglas for his love and support. Without you, this experience would not have been the same. Thank you.

Doctorate of Public Health Integrative Statement

The Doctorate of Public Health is intended for public health practitioners aiming to hold leadership positions in the future. The need to understand how to apply scientific knowledge towards health gains poses a major challenge in organizations working in public health. This professional doctorate equips students with essential skills and abilities to lead organizations working towards public health policies and practice. The main differences from an academic doctorate are that it is a more structured course with different elements; it has a taught element and is linked to the professional practice through the professional attachment. The thesis is generally, but not always, oriented to tackle problems within the scope of public health practice and often is policy oriented. It is shorter than a PhD thesis (50,000 words) and is expected to be completed within 18 months (LSHTM, 2006).

The programme integrates three elements. The first is a taught element comprising six modules. The first three modules are mandatory and include two on evidence-based public health and one on leadership and management. The second three modules can be chosen from all those offered at the school. The choice, in my case, was made based on the skills required for the other two components of the degree. Planning to undertake research using qualitative methods with a social sciences and organizational perspectives, I chose one module on qualitative research and one on medical anthropology. I also studied one module on evaluation of health programmes as a contribution to my future professional career and one non-assessed extra module on principles of social research. I obtained a very good pass in the final assessment of five of the six mandatory modules and one good pass in another one (the extra one was not counting towards the final degree score).

The second element of the DrPH is a professional attachment. It consists of an in-depth analysis of an organization working in public health through an internship arranged by the student for a period of generally three to six months. The aim of this element is to develop understanding of how to design and develop public health organizations (LSHTM, 2006). In my case I chose the World Health Organization Country Office in Cambodia. Being interested in workforce and human resources (HR), I chose to use that area as an entry point for analysis. The results were presented in the report “World

Health Organization Country Office Cambodia: Responding to Human Resources Development”(Alonso-Garbayo, 2004). The report was used by the organization to support the introduction of some changes in their organizational and management systems. During the course of the assignment for the professional attachment I was involved in the work that WHO does in the area of HR mainly as a counterpart of the Departments of Human Resource Development and Personnel of the Ministry of Health. That allowed me to complement my knowledge about the problems related to HR in developing countries and more specifically those affecting Cambodia. I was also involved in the day-to-day work of the organization, attending meetings and getting involved in internal activities such as specific task groups about human resources or as a member of the team discussing internal issues what allowed me to understand the culture and dynamics of the organization. I obtained a good pass (B) in the assessment of this element.

The third element of the DrPH is a research project leading to a thesis. This element aims at providing research skills and to improve understanding of the role of research in public health practice. My area of research was human resources and more specifically the phenomenon of migration of health professionals working in the public health system. Specifically the research examines how the expectations about the UK of nurses recruited in India and the Philippines by a Hospital Trust in London, change through the process of adaptation to their new environment and the extent to which they are met and how that influences their career development and their intention to stay or to move forward.

After I qualified as a nurse, my professional career started in 1985 as a clinical nurse working for eight years in the Spanish NHS, mainly in intensive and emergency care. Since then my work moved into international health with an initial interest in humanitarian work that later shifted into issues related with health systems development and health policy. My career has progressively advanced towards positions of responsibility with different organizations, from NGOs to UN and Government organizations mostly providing advice on health policy, management and systems development issues.

At the academic level, after my basic nursing studies at the Universidad Complutense de Madrid, I was involved in a number of courses to improve my managerial skills, first oriented to the Spanish health system and later more focussed on international health. After six years working at this level I decided to improve my understanding of the decision making process in the health sector and I studied a Masters in Sciences degree in Health Policy, Planning and Financing at the London School of Economics and Political Sciences and the LSHTM (intercollegiate). The course improved my understanding of organizations working in public health such as Ministries of Health. After the MSc I returned to the field and worked with UN organizations (e.g. UNFPA and WHO) in different areas such as reproductive health and Polio eradication. I also worked as a freelance consultant mainly on evaluation of health care programmes in developing countries. In 2000 I got a position as Health Policy and Management Advisor for the World Bank managed Health System Rehabilitation and Development Programme in East Timor. The assignment covered the period one year after the violent withdrawal of Indonesia until a few months after the declaration of Independence in May 2002. It was during those years that I developed a special interest in the area of human resources for health. Being in a country with a critical shortage of key health professionals (e.g. only 25 doctors remained after the withdrawal of Indonesia), I developed a special interest on this specific problem. International recruitment was part of the solution found for East Timor which posed great challenges to the newly established Ministry of Health and personally to me as an adviser in that area (Alonso-Garbayo, 2004). The complexity of rehabilitating the health system, particularly in the area of human resources, contributed to my decision to come to the LSHTM to pursue my DrPH with a focus on issues of human resources. My main objective was to improve my capacity in similar situations including the analysis and exploration of issues with a scientific approach. Workforce issues have globally attracted great attention in the last years and are now recognized as a major bottleneck in the achievement of Global Health Goals and the success of public health programmes (WHO, 2006). The increasing attention in this area and the growing number of academic and professional events related to this important area has provided me with the opportunity to present my research findings in different forums including two international conferences and two research workshops which has contributed to building my profile as a specialist in this area and also to the dissemination of the findings of this study. I am also planning to publish the results of my research in the form of scientific

articles in international journals. A research report will be also sent to the Trust where the study was undertaken.

The Doctorate in Public Health has provided me with skills that will be invaluable in my future professional career. Working at the LSHTM has once again, proved to be greatly enjoyable and doing it under the supervision of Professor Gill Walt a great opportunity to learn and grow in my personal and academic experience.

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List of abbreviations

BEM	Black and Ethnic Minorities
DoH	Department of Health
DrPH	Doctorate of Public Health
ERG	Existence, Relatedness and Growth
FNIF	Florence Nightingale International Foundation
HR	Human Resources
HRH	Human resources for health
HSJ	Health Service Journal
ICN	International Council of Nurses
IELTS	International English Language Test System
IRN	Internationally Recruited Nurses
LSHTM	London School of Hygiene and Tropical Medicine
NCLEX-RN	National Council Licensure Examination for Registered Nurses
NGO	Non-Governmental Organization
NHS	National Health System
NMC	Nursing and Midwifery Council
OECD	Organization for Economic Co-operation and Development
OME	Office of Manpower Economics
ONP	Overseas Nurses Programme
PA	Professional Attachment
PNAA	Philippines Nurses Association of America
RCN	Royal College of Nurses
REC	Research Ethics Committee
RN	Registered Nurse
TB	Tuberculosis
UKCC	UK Central Council for Nursing, Midwifery and Health Visiting
UN	United Nations
UNFPA	United Nations Fund for Populations
WHO	World Health Organization
WTE	Whole Time Equivalent

Chapter 1: Introduction

Global nursing workforce crisis

The size of the global health workforce is estimated to be over 59 million health workers including almost 20 million support workers and managers. These health workers, often referred to as human resources for health (HRH), are distributed unequally and inequitably around the globe. Areas with a higher burden of disease are those with a lower density of health workers (WHO, 2006); while North America has more than 18 workers per 1,000 population, Sub Saharan Africa has only one per 1,000 population (JLI, 2004).

Human resources for health (HRH) deficits represent a major problem for public health systems in developing and developed countries (Walt, 1998; Finlayson et al., 2002; Buchan, 2002a; Dovlo, 2003; Marchal and Kegels, 2003; ICN and FNIF, 2006; WHO, 2006). The deficit at a global level is estimated to be around four million health workers (JLI, 2004; WHO, 2006); constituting a major barrier for the achievement of international health goals (Buchan and Calman, 2004; ICN and FNIF, 2006; WHO, 2006), the success of global health programs (Marchal and Kegels, 2003; Ncayiyana, 2004; WHO, 2006) and the ability of health systems to deliver health care to their populations. There is evidence that the density of health workers is strongly related to health outcomes such as survival of mothers, infants and children (WHO, 2006).

It is widely agreed that there is a global shortage of nurses. The main reasons are multifaceted and complex. On the one hand the demand for nurses is progressively increasing due to population growth, ageing of the population and increase in the burden of chronic and non-communicable diseases. On the other hand the supply of nursing professionals is declining and is expected to decline further (Buchan, 2002a; Antonazzo et al., 2003; Awases et al., 2003; Aiken et al., 2004; WHO, 2006). Contributing to this decline there is evidence of high attrition among nursing professionals. The main reasons are low salaries and poor work environments leading to low motivation and turnover (Baumman, 2007). The short supply of nurses is particularly severe in low income countries due mainly to limited supply of nurses, one of the main reasons being migration – or the brain drain (Wadda, 2000; Friedman, 2004;

Padarath et al., 2004; Scott et al., 2004). In Sub-Saharan Africa alone the shortfall is estimated at 600,000 nurses (ICN and FNIF, 2006).

The global stock of nurses appears to be insufficient to cover world needs. In developed countries nursing workforce stocks have declined in the last decade and as shown in Table 1 there are predictions of shortfalls in the near future (Aiken et al., 2004).

Table 1 Country Registered Nurse (RN) Workforce and Foreign Nurses' Contribution

Country	RNs in workforce (foreign RNs as % of total workforce)	Predicted shortfall (shortfall year)
USA	2,202,000 (4%)	275,000 (2010) 808,000 (2020)*
UK	500,000 (8%)	53,000 (2010)
Canada	230,000 (6%)	78,000 (2011)
Australia	179,200 (?)	40,000 (2010)
Ireland	49,400 (8%)	10,000 (2008)

Adapted from (Aiken et al., 2004) # (Bureau-of-Health-Professions, 2002)

However, some countries have been producing more health workers than they can employ. Buchan et al. (2003) estimated that 85% of Filipino-employed nurses are working abroad (Buchan et al., 2003). India, Spain and China recently signed bilateral agreements with the UK Department of Health to facilitate emigration of their reportedly nursing workforce surplus (DoH, 2005).

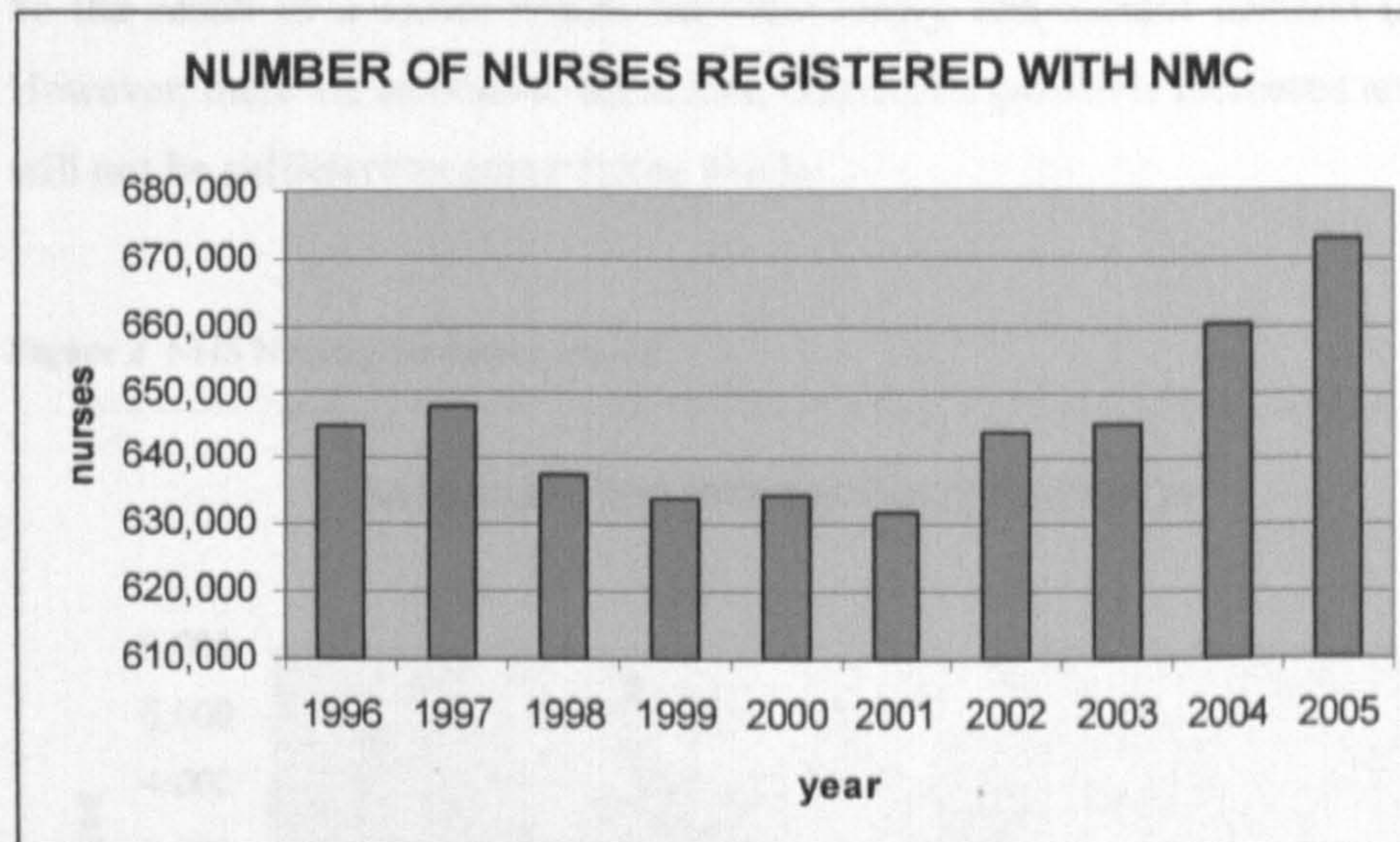
The British nursing labour market

Disparities and gaps in health workforce information from different organizations make the analysis of the UK nursing labour market difficult (Buchan and Seccombe, 2005). Registration with the Nursing and Midwifery Council (NMC) is compulsory in the UK as a prerequisite for practice. However not all registered nurses are necessarily active. Therefore NMC data reflect information about intention to work in the UK rather than actual working. As shown in Figure 1 there has been an increase in the nursing workforce during the last decade.

The total number of nurses increased from 645,011 in 1996 to 682,220 in 2006 (5.7%), with the number of initial registrations increasing from 19,632 to 31,402 (59.9%) over the same period. However, the number of nurses leaving the register (wastage) also

increased from 17,572 in 1996 to 25,515 in 2006 (NMC, 2006). Current levels of wastage compared with that one decade ago, represent a net increase of 18.5%. Wastage figures doubled from 2.3% in 1997 to 4.7% in 2003 (NMC, 2005c).

Figure 1: NMC Register Dynamics (1996/2005)



Source: Author's analysis of data from NMC (NMC, 2005c)

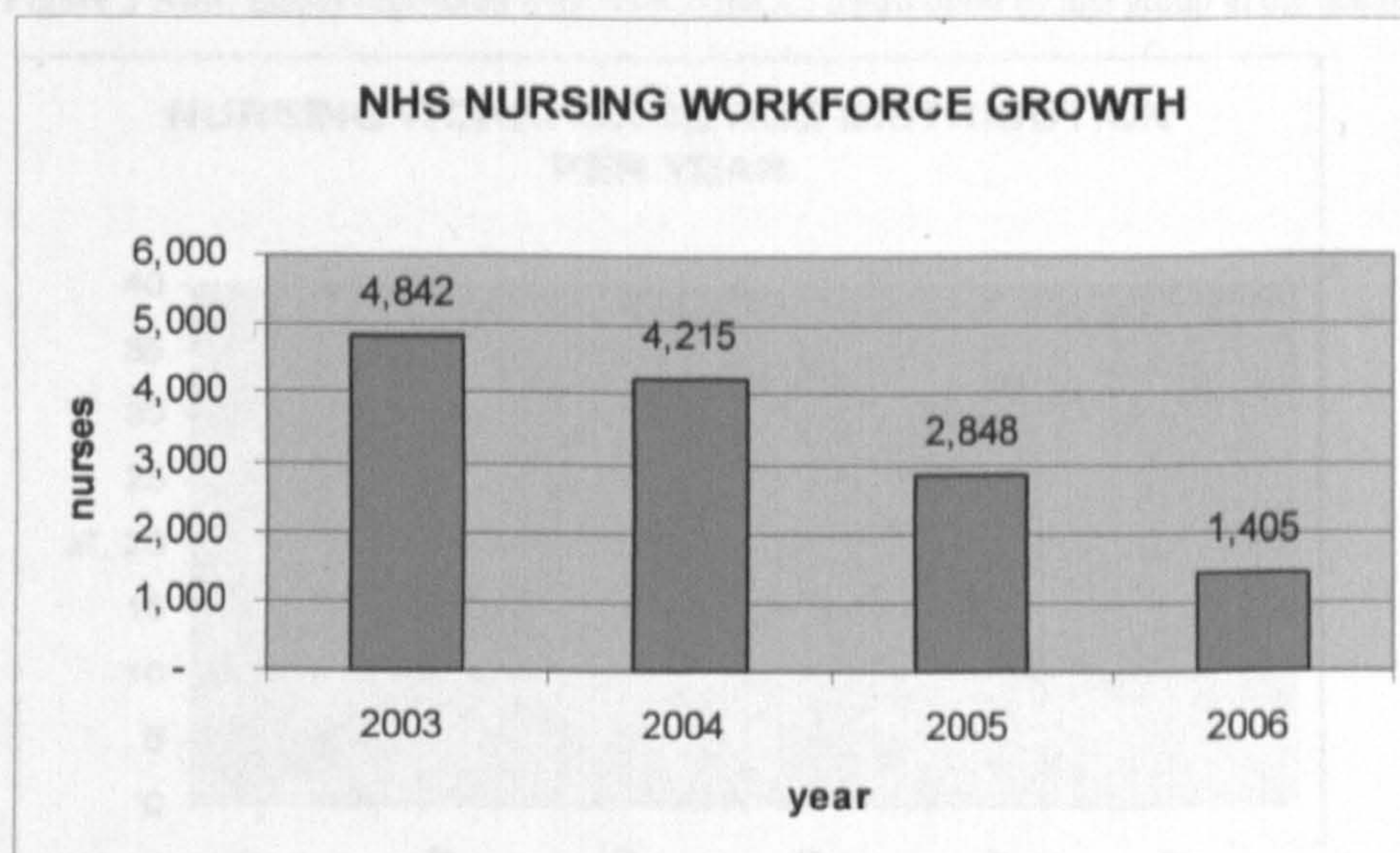
About 75% of all working nurses in the UK are employed by the NHS (Buchan et al., 2006). Nursing and midwifery staffing in the NHS declined 26% from 1987 to 1997 (Maynard, 2000) and in July 2000, the NHS launched a plan for reform which included an increase of 20,000 in the number of nurses (NHS, 2000). The strategies proposed to achieve those targets included an increase in production, an improvement in retention, facilitating the return of non-practising staff and international recruitment. Within the NHS, the number of whole time equivalent (WTE) nursing staff in all the UK, increased from 309,992 in 1997 to 381,624 in 2005 an increase of 23.1%. In England alone the number of nurses went from 246,011 to 307,744, an increase of 25% in the same period (Buchan and Seccombe, 2006a).

However, the net growth in the number of registered nurses (number of nurses joining - nurses leaving) working for the NHS in England and Wales has been decreasing over the last four years from 4,842 nurses in 2003 to just 1,405 in 2006¹. As shown in Figure

¹ Data cover the period 1 April one year to 31st March next year

2, if the trend continues, zero growth could be expected soon (OME, 2003; OME, 2005a; OME, 2005b; OME, 2006). These figures could be overestimated as data are derived from a national survey of NHS Trusts with a low response rate and they might not represent Trusts performing poorly. Thus the figures should be interpreted cautiously (Buchan and Seccombe, 2005). This was claimed by the Health Minister to be the result of a closer match between supply and current demand (DoH, 2006b). However, there are reasons to think that, unless this growth is increased and sustained, it will not be sufficient to cover future needs.

Figure 2 NHS Nursing workforce growth



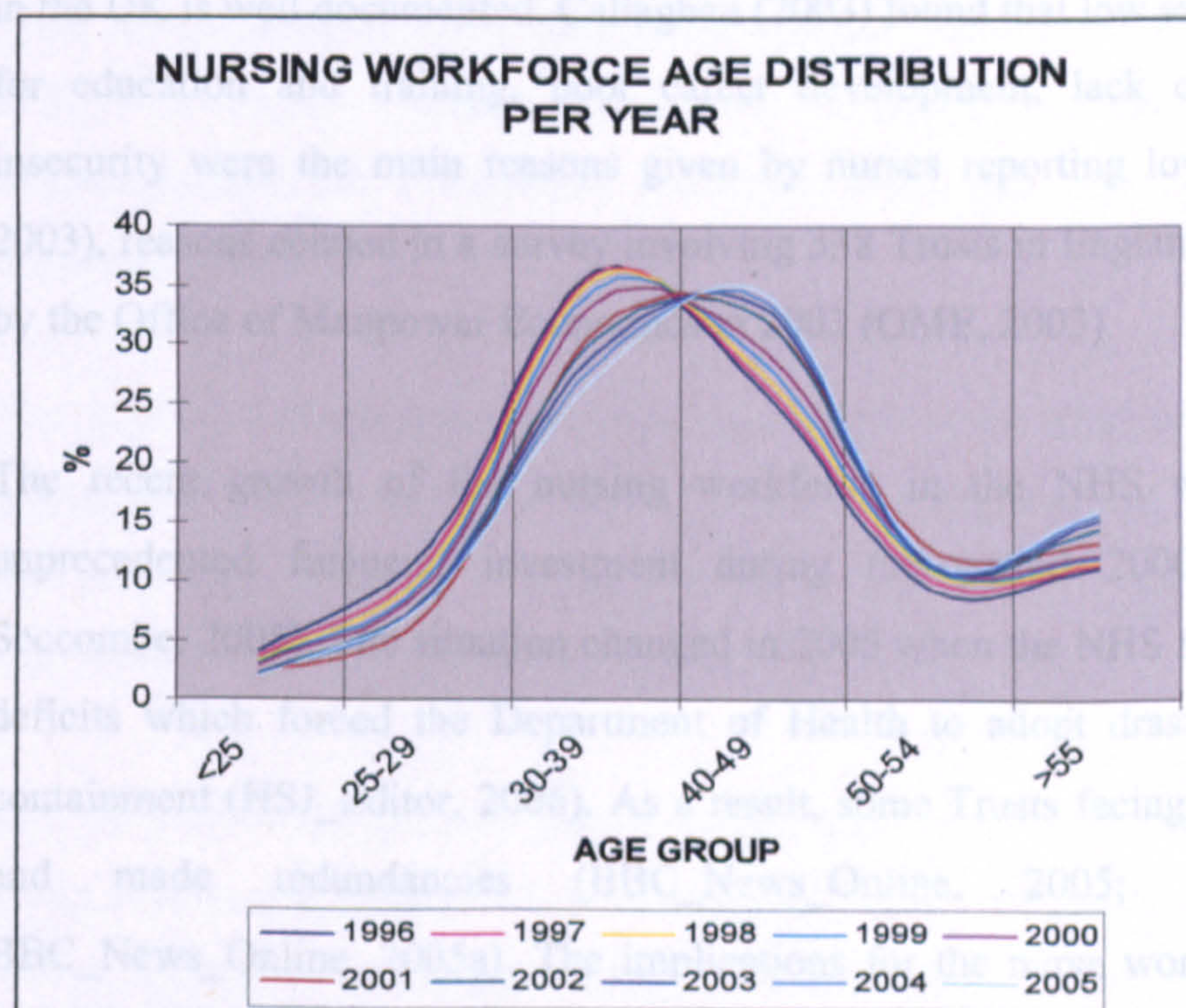
Source: Author's analysis of data from (OME, 2003; OME, 2005a; OME, 2005b; OME, 2006)

In the USA, Canada, Australia and other industrialised countries the nursing workforce is aging and approaching its retirement age (Buchan et al., 2002; Buchan, 2002a; Antonazzo et al., 2003). In the UK, the average age of nurses registered with NMC also increased during the last decade (see Figure 3), and around 150,000 nurses will reach retirement age in the coming five to ten years (Malone, 2006). Younger age groups are also tending to decrease, with nurses joining the workforce later. The retirement age remains unchanged resulting in a shorter active professional life (NMC, 2005c).

The NHS has greatly increased health care activity in the last years. In England the number of acute elective and emergency hospital admissions went from 7.5 million in 1992/93 to 9.9 million in 2004/05 (+ 33.2%). The number of emergencies attended in

A&E (only new attendances) went from 11 million in 1992/93 to more than 16 million in 2004/05 (+ 52%). New patients attended in outpatient services went from 9 million in 1992/93 to more than 13 million in 2003/04 (+ 43.7%) (DoH, 2006a). Advances in medical technology and the extension of nursing roles, with nurses assuming responsibilities previously assigned to other health professionals (NHS, 2000) are also increasing the demand for nurses (Gerrish and Griffith, 2004). Nurse practitioners in the UK, for example, have been providing consultations since 1992, having progressively assumed tasks such as prescribing or minor surgery that were previously performed by physicians (RCN, 2002).

Figure 3 NMC nurses registered with NMC/UKCC: distribution by age group in the last decade



Source: Author's analysis of data from (NMC, 2005c)

An ageing population will require more nursing care (ICN, 2001; Tjadens, 2002; Zurn et al., 2002; Buchan, 2002a; Hasselhorn et al., 2003; Buchan and Dovlo, 2004). In the UK, the number of people aged 85 and over grew by 64,000 (6 per cent) in 2004/5 reaching a record of 1.2 million. This trend is expected to continue during the first half of the century (ONS, 2006).

Gerrish and Griffit (2004) argue that, in the developed world, a poor image of the nursing profession and the increased opportunities for women in the labour market

attract fewer new applicants to nursing schools (Gerrish and Griffith, 2004). However, in the UK, after a decline occurred during the first half of the 1990s, the number of new entrants to the register from pre-registration education has increased from 12,082 in 1997/8 to 20,587 in 2004/5. However not all complete their training. For example, in Scotland the proportion of nursing students completing their 3-years courses declined from 64.2% in 1998/99 to 56.6% in 2002/03 (RCN, 2004).

In a study across ten European countries about intentions to leave the nursing profession it was found that 36.2% of UK nurses were considering leaving (Hasselhorn et al., 2003). The problem of “burn out” and low morale among nurses working for the NHS in the UK is well documented. Callaghan (2003) found that low salaries, lack of support for education and training, poor career development, lack of resources and job insecurity were the main reasons given by nurses reporting low morale (Callaghan, 2003), reasons echoed in a survey involving 338 Trusts in England and Wales, reported by the Office of Manpower Economics in 2003 (OME, 2003).

The recent growth of the nursing workforce in the NHS was the result of an unprecedented financial investment during the period 2000-2004 (Buchan and Seccombe, 2005). The situation changed in 2005 when the NHS faced serious financial deficits which forced the Department of Health to adopt drastic measures for cost containment (HSJ_Editor, 2006). As a result, some Trusts facing deficits closed wards and made redundancies (BBC_News_Online, 2005; Mullholland, 2005; BBC_News_Online, 2005a). The implications for the nurse workforce are important. Measures such as reductions in agency staff, putting a freeze on new expenditure, imposing vacancy freezes and reducing staff were still being implemented in 2006 (Buchan and Seccombe, 2006a), and it has been suggested that nurses are being replaced by non-qualified professionals, such as Health Care Assistants (Bach, 2005)

As a result of the growth in the nursing workforce and the financial crisis mentioned above, international recruitment of junior nurses (bands 5 and 6) was limited in 2006 to countries within the EU area (DoH, 2006b). This decision was made in spite of increasing evidence presented above predicting relapsing shortages of nurses in the coming years. The inadequacy of this measure was highlighted by the RCN:

"Removing nursing from the list of recognised shortage professions is short-termism in the worst possible sense. [...] Over 150,000 nurses are due to retire in the next five to ten years and we will not replace them all with home grown nurses alone."
(Malone, 2006)

With this scenario it is likely that the UK government will be forced to reconsider its current policy and re-introduce the recruitment of overseas nurses who will not otherwise be produced in sufficient numbers in the UK or in Europe.

International recruitment

More than a third of nurses registered with the NMC were trained overseas². From 1997, over 80,000 overseas nurses were registered with the NMC, most of them migrating from the Philippines, Australia, India and South Africa (Buchan and Seccombe, 2006b).

The number of overseas nurses newly registered with the NMC between April 2002 and March 2003 was 13,041 of a total of 36,811 new registrations (35%) (NMC, 2004b). The proportion in 2004 - 2005 was maintained at similar levels with 11,477 overseas nurses registered from a total of 33,257 (35%) (NMC, 2005c).

The distribution of overseas nurses in the four countries of the UK is uneven. This group represented around 1.8 % of the total nurses registered in Scotland, 3.1 % in Wales, 2.7% in Northern Ireland and 7.8% in England. Within England the proportion in London is much higher than the rest of the country with around 25% of registered nurses being from overseas (Buchan et al., 2005).

Since 2002, India and the Philippines have been providing more than half of the overseas nurses to the NMC (NMC, 2005c). As shown in Table 2 the proportion of Indian nurses went from 1% of the total overseas input to the NMC registry in 98/99 to 40.9% in 05/06 and the proportion of Filipino nurses went from 1% to 17.8% in the

² In this study the term overseas nurses is used to identify nurses that were trained overseas. Internationally Recruited Nurses (IRNs) refers to nurses trained and actively recruited abroad, often in their country of origin.

same period. Although the number of Indian nurses grew steadily in that period, there is a decreasing proportion of Filipino entrants since 2002 (NMC, 2006).

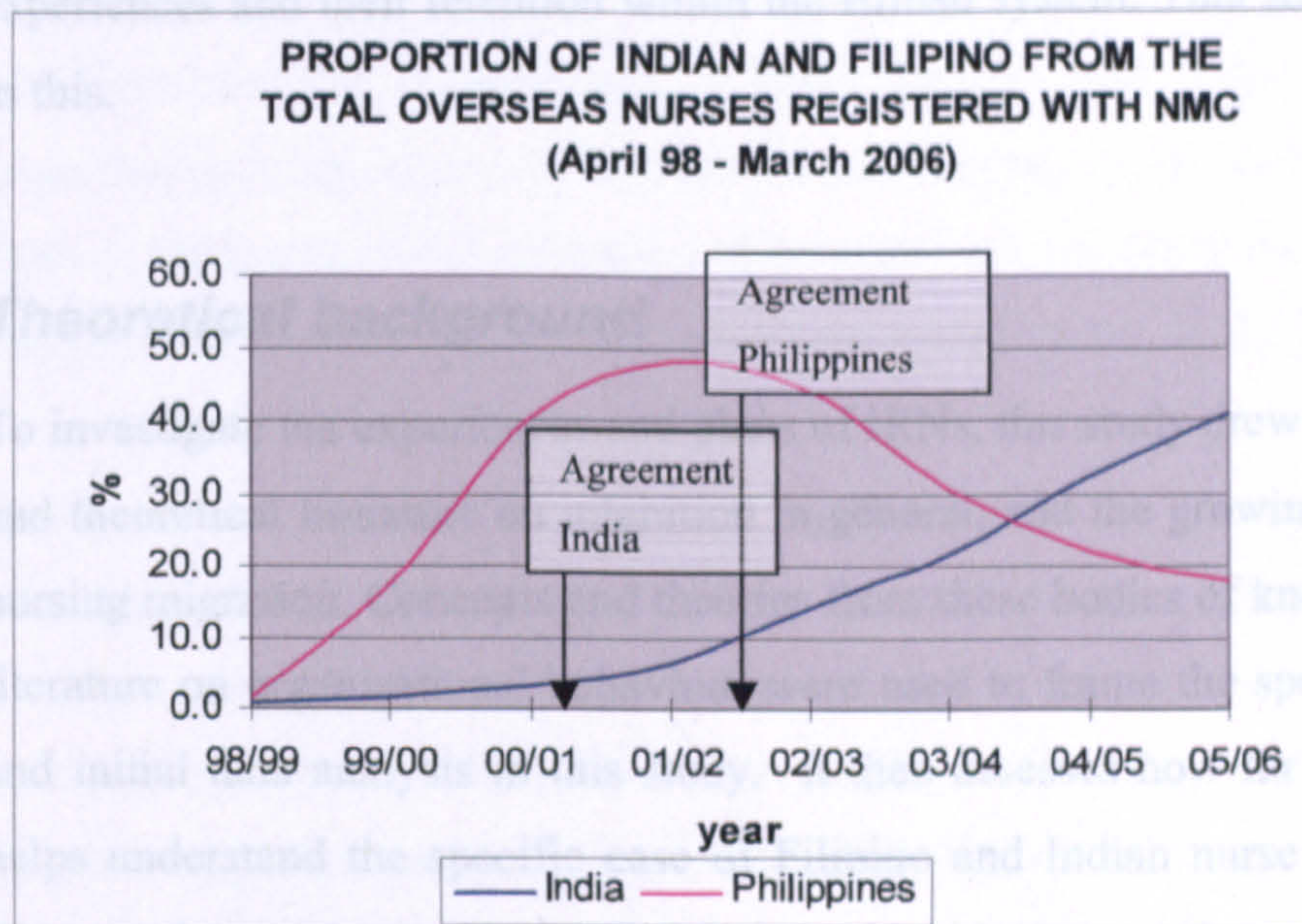
Table 2 Indian and Filipino nurses registered with the NMC as % of total overseas nurses

SOURCE COUNTRIES	98/99		99/00		00/01		01/02		02/03		03/04		04/05		05/06	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
India	30	1	96	2	289	3	994	7	1,830	14	3,073	22	3,690	32	3,551	40.9
Philippines	52	1	1,052	18	3,396	40	7,235	48	5,593	44	4,338	31	2,521	22	1,541	17.8
TOTAL	3,621		5,945		8,403		15,064		12,730		14,122		11,477		8,673	

Source: (NMC, 2005c; NMC, 2006)

This growth reflects the active recruitment undertaken by the NHS in both countries since the introduction of guidance for international recruitment. In October 2001 a Code of Practice for National Health Service (NHS) employers was issued (DoH, 2001). The policy, which was revised in 2004 (DoH, 2004), reflected Department of Health's acceptance that international recruitment should not be from countries with nursing deficits themselves (DoH, 2004b). The DoH policy is seen as a legitimate solution to the problem of the shortage of nurses and it recommends the use of only those recruitment agencies adhering to the guidance. However, the policy does not regulate the private sector and not all recruitment agencies adhere to it (DoH, 2004a). As a result overseas nurses recruited by the private sector coming from countries included in the DoH list of banned countries are later recruited by NHS employers who argue that they comply with DoH guidance (Bach, 2007).

An agreement was reached in January 2001 between the Indian and the UK Governments enabling and promoting the NHS to recruit nurses in that country. This explains the steady increase in the proportion of Indian nurses, as shown in Figure 4 (NMC, 2005c; NMC, 2006). Despite active recruitment having been undertaken by NHS Trusts in the Philippines since the late 1990s, the Government of The Philippines signed an agreement with the UK in 2002 to facilitate the emigration of Filipino nurses. The agreement included economic terms such as the obligation for the NHS to pay for immigration and registration fees and airfares as well as other requirements related to induction and good practice (Bach, 2006). The trends in recruitment in India and the Philippines shown in Figure 4 reflect the change in preferences by NHS recruiters between both countries showing an inclination towards India since 2001-2002.

Figure 4 Proportion of Indian and Filipino Nurses from Total Overseas Nurses registered with NMC

Source: (NMC, 2005c; NMC, 2006)

International recruitment of nurses is expensive. Initially nurses had to cover their own moving expenses but more recently that responsibility has shifted to the employer (Maybud and Wiskow, 2005). In the UK the cost of a private recruit in 1999 was between 8% and 14% of an annual nurse's salary (DoH, 1999). Efficiency of international recruitment can only be achieved if the initial investment on overseas nurses ensures a long-term engagement with the employer, but there is some evidence suggesting that, once recruited, internationally recruited nurses (IRNs) do not stay in the NHS for long. Nurses in the UK have to renew their registration in the NMC every three years. Of the internationally recruited nurses registered in 1995, 56% did not renew their registration in 1998, suggesting that their length of stay in the UK NHS may be short (Buchan and O'May, 1999). Buchan et al. (2005) found that 63% of the Filipino nurses and around 25% among those from India, Pakistan and Mauritius were planning to move to another country, with around 40% planning to leave in the next two years (Buchan et al., 2005). It is important to note that this data refers only to the intention to leave and not to actual turnover. However, while there is evidence of the reasons for turnover behaviour of British nurses (Packard and Motowidlo, 1987; Blegen, 1993; Knoop, 1995; Hutt and Buchan, 2005; Hayes et al., 2006) there is very little evidence in this regard for overseas nurses. They might be susceptible to different incentives than

locally qualified nurses. There is therefore a need to increase knowledge about the motivation, the experiences and the plans of overseas nurses to improve their experiences and their retention within the British system. This study aims to contribute to this.

Theoretical background

To investigate the experiences and plans of IRNs, this study drew on the large empirical and theoretical literature on migration in general, and the growing body of research on nursing migration. Concepts and theories from these bodies of knowledge, and from the literature on organisational behaviour were used to frame the specific areas of interest and initial data analysis in this study. It then assesses how far the existing literature helps understand the specific case of Filipino and Indian nurse migration to the UK. This section reviews this literature, and provides some theoretical background and contextual information on migration and organizational behaviour related to this specific case.

Migration theories

Human migration denotes the movement of human from one place to another often over long distances and in groups. Scholars have been analysing migration for many years without reaching a consensus on one single explanation that captures and explains all the different aspects of this complex phenomenon. Arango (2000) suggests that there is no such thing as one general migration theory, but that different disciplines can help explain migration. Instead of building a sequence of contributions leading to a general migration theory, researchers have used different models, frameworks and conceptual approaches to explore this multifaceted phenomenon. Essentially he argues that one theory of migration alone would not be able to explain such a complex phenomenon (Arango, 2000).

Neoclassical explanations see migration from a purely supply and demand perspective (Lewis, 1954; Sjaastad, 1962; Todaro, 1969; Piore, 1979). However, migrants are also influenced by social and cultural forces rather than just by economic motives. The migration networks theory, with a more socio-political perspective, focuses on the

development of a network infrastructure that facilitates migration and the importance of not only the individual, but the household and community levels on explaining migration (Massey et al., 1987). Migration also follows former colonial, geographical and linguistic ties (Connel and Stilwell, 2005). With a broader perspective, the migration systems approach suggests a tension between on the one hand the idea that there is an international migration system and on the other hand that migration is a process within some broader conceptualised system (Kritz et al., 1992).

Having reviewed different theoretical approaches to the phenomenon of migration it was decided that a broad perspective would be the most appropriate. This study therefore uses an adaptation of the model developed by Van-Hear (1998) based on economic theories of migration (Massey et al., 1993) and modified and supplemented by other migration theories (Van-Hear, 1998). The model suggests aspects that need to be examined in order to understand migration. These are the individual decision-making, the household decision-making, the disparities between places of origin and destination, the migrant networks, the regulatory context in which migration takes place (migration regime) and the macro-political environment. This study draws specifically on Van-Hear's individual (push and pull factors), social (household and migratory networks) and cultural (history, religion and gender) perspectives of migration and examines the regulatory context surrounding international migration of nurses and the disparities between origin and destination countries in terms of nursing practice.

Individual perspective: push, pull and regulatory factors

Despite being influenced by multiple factors, the decision to emigrate is essentially a personal one (Stilwell et al., 2004) resulting from individuals weighing the benefits and the cost of migration. In order to understand this trade off, this study uses the push and pull factors theory, initially proposed by Ravenstein (1885) in the late 1800's (Ravenstein, 1885) and reintroduced by Lee (1966). The theory is still commonly used to explain migratory movements of health workers today (Mejía et al., 1979; Allan and Larsen, 2003; Buchan, 2003; McGonagle et al., 2004; Bach, 2004a; Astor et al., 2005; Larsen et al., 2005; Kingma, 2006; Smith et al., 2006; Winkelmann-Gleed, 2006) which attests to its flexibility and clarity.

Push factors are those forces in countries of origin that impel workers to emigrate. Pull factors are those from destination countries that attract professionals (Dovlo, 2003; Kingma, 2006). Pull and push factors are commonly opposite aspects of similar phenomena in source and destination countries (Mejia, 1978a; Kingma, 2006). Buchan et al. (2003) argued that the extent of the gap between both sides determines the strength of the pulling influence from destination countries (Buchan et al., 2003). These two factors determine the direction of the flow by attracting or repelling health workers. Other factors such as professional regulations (registration and licensing) and migration and labour policies in source and destination countries modulate the size of the flow (Mejia, 1978b). A large set of push, pull and regulatory factors have been identified from this literature as suggested in Table 3.

Table 3 Factors fostering migration

PUSH	PULL	REGULATORY
<ul style="list-style-type: none"> • Relatively low salaries • Relatively poor working conditions • Relatively limited opportunities for career progression • Relatively poorly resourced health system • Relatively less opportunities for professional development • Relatively low professional fulfilment (India) • Poor social recognition of nursing (India) • Perceived worse quality of life • Perceived worse security • Fewer opportunities for child education • HIV/AIDS • Economic instability • High unemployment • Socio-cultural factors 	<ul style="list-style-type: none"> • Relatively high salaries • Relatively good working conditions • Relatively safe work environment • Relatively well resourced health system • Relatively more opportunities for career progression • Relatively more opportunities for professional development • Perceived better quality of life • Perceived better security • More opportunities for child education • Safer socio-political environment (asylum) • Shortage of nurses • Active recruitment • History of colonial influence • Family and social support (Diaspora) • Common language 	<ul style="list-style-type: none"> • Professional registration and licensing regulations • Immigration and emigration laws and procedures • Employment regulations • Codes of Practice • Bilateral agreements

Source: Adapted from (Mejia, 1978a; Mejia, 1978b; Daniel et al., 2001; Kingma, 2001; Xaba and Phillips, 2001; Allan and Larsen, 2003; Buchan et al., 2003; Buchan et al., 2003; Khadria, 2004; Padarath et al., 2004; Larsen et al., 2005; Kingma, 2006; Smith et al., 2006; Winkelmann-Gleed, 2006)

Bach (2007) from an industrial relations perspective argues that the role of the state both at source and destination and labour market institutions such as employers, and recruitment agencies can contribute to understand nurse migration in the UK (Bach, 2007). Following this perspective and in order to have a broad view of the phenomenon of nurse migration, this study, therefore, incorporates an exploration of the NHS as the employer and the role of the recruitment agencies involved.

Theories about migration have been used to explain movements among specific professional groups but the study of nurse migration is a relatively new area. Although limited, there is an incipient body of literature about nurses' motivations for migration. Most scholars agree that they relate to professional, economic, social and personal reasons (Kingma, 2001; Xaba and Phillips, 2001; Allan and Larsen, 2003; Awases et al., 2003; Buchan et al., 2003; Astor et al., 2005; Kingma, 2006; Smith et al., 2006; Thomas, 2006).

At economic level most studies found that on the pull side, economic improvements, employment availability, ensuring retirement and expectations to improve quality of life were the main reasons for nurses to emigrate (Daniel et al., 2001; Allan and Larsen, 2003; Vujicic et al., 2004; Smith et al., 2006; Winkelmann-Gleed, 2006). In regard to employment availability some authors argue that the shortages of nurses in developed countries and active recruitment constitute important pull factors for nurses from developing countries (Findlay, 2002; Stilwell et al., 2004; Winkelmann-Gleed, 2006). Nurses are often seen as exclusively economic migrants, but studies suggest this represents a misunderstanding of nurses motives (Larsen et al., 2005), which included professional motives as a very strong incentive for migration, sometimes outweighing economic factors (Awases et al., 2003). Thomas (2006) suggests that nurses in lower income segments of society tend to migrate more than those with better economic status, with the incentive to migrate depending on the prospective income gains from migration. However, other authors argue that the most skilled and experienced nurses are the ones that emigrate (Brush and Sochalski, 2007; Salmon et al., 2007).

From a professional perspective, issues related to professional development such as access to continuous education, work experience or working within high nursing standards were common in most of the studies (Daniel et al., 2001; Allan and Larsen,

2003; Khadria, 2004). Less experienced nurses leave their countries looking for opportunities to apply their recently acquired knowledge and skills while senior nurses leave in search of a better professional career (Kingma, 2001). Other professional factors suggested are more related to the work environment such as access to better technology, availability of clinical resources, improved management, or professional autonomy (Xaba and Phillips, 2001; Smith et al., 2006). Nurses also expect to have greater responsibility in the ward and to undertake complex tasks (Daniel et al., 2001).

Other factors pushing nurses to leave their countries are conflict, insecurity or political instability. They seek asylum in safer countries using their nursing skills to find employment and settle (Buchan, 2003; Kingma, 2006; Winkelmann-Gleed, 2006).

Arango (2000) argues that to analyse migration, using theories that explain only why people move, is a limited approach. There are people in countries of origin living in the same conditions as migrants who decide not to move. He proposes that broadening the focus from individual to societal perspectives of migration, including the social costs of adaptation to the new environment, is needed (Arango, 2000).

The social perspective: family and migratory networks

As suggested by Van-Hear (1998), apart from individual decision-making and motivation, the scope of exploration should be opened to the household level as the essential unit where decisions about migration are often made. He also recommends exploring the disparities between origin and destination countries and the different migrant networks (Van-Hear, 1998).

Scholars have provided evidence about the impact that migration has on the family of migrant nurses (Allan and Larsen, 2003; Parreñas, 2003; George, 2005), but little is known about the role played by the family in the decision of nurses to emigrate. However, there is evidence about the fact that family is often behind the decision to emigrate (Reynolds, 2002; Khadria, 2004; Vujicic et al., 2004). Percot (2006) argues that in India the investment that a family needs to make for a daughter to undertake nursing studies is often paid back by nurses after graduation with remittances sent back from abroad. In that sense migration is not an individual decision but one influenced by

families (Percot, 2006). In the Philippines, migrant nurses are expected to support other family members economically and this constitutes a main motivation for them to undertake nursing studies and to emigrate (Smith et al., 2006). Allan and Larsen (2003), in their study about a multinational sample of overseas nurses, found that family obligations such as the education of children, or joining the spouse were linked to the decision to emigrate. Migration in that sense was found not to be an individual but a familial strategy (Allan and Larsen, 2003).

The impact that migration has on the family of overseas nurses is explored from a feminist perspective in George (2005). She suggests that the change in family roles inherent to migration affects family dynamics. Gender relations within households of migrant women adapt to women's work requirements. She argues that men moving with these nurses often lose their role of breadwinners, which is perceived as a threat to their otherwise pre-eminent position within the familial structure. In her study of migrant nurses from Kerala she found that often these men attempted to replicate their pre-migratory power role by enrolling in activities considered to be socially important such as those related to church communities thus favouring a reintegration of the patriarchal structure (George, 2005). But nurses often emigrate leaving their families in their countries. The social cost of migration for the families of migrant nurses that are left behind is often great, particularly when there are children in the family. Parreñas (2003) suggests that Filipina migrant mothers are subject to vilification from a section of the society, which claims that female migration is only acceptable when there are no children or spouses. She found that children left behind by migrant mothers were more susceptible to psychological and developmental problems than those who grew up with their mothers. She defends the right of women to emigrate and look for a better life for themselves and their families, advocating for social acceptance of the right of these mothers to migrate (Parreñas, 2003).

The self-organized groups of migrants in destination countries constitute the often called Diaspora networks (Kuznetsov, 2006). In their study Martineu et al (2002) briefly mention the role that Diaspora networks play in the process of migration of nurses. Friends and families help each other to make the decision to emigrate and then to assimilate or "feel at home" (Martineu et al., 2002; Kingma, 2006). Often migrant nurses establish organizations in destination countries. These organizations are

suggested to represent an important Diaspora network that promotes migration (Bach, 2003).

Push and pull factors often deal with migration from a relatively isolated perspective and do not always include acculturation aspects. Examining concepts such as culture and history is therefore important to locate individual and family decisions within a broader context.

The cultural perspective: history, religion and gender

Former colonial powers exert an attraction on formerly dominated societies after their independence. That is the case among nurses attracted to Britain from India or to the U.S. from the Philippines. British influence on Indian nursing is first documented during the second half of the 19th century when Florence Nightingale showed interest in the situation of British soldiers, during the Indian Mutiny (1857/58). In 1888 some British nurses arrived in India to take care of British soldiers followed in 1905 by many missionary nurses who arrived in India to join the Missionary Medical Association. Nursing started to be regulated and schools opened following educational standards proposed mostly by British missionary nurses. The first Board of Examination for nurses was established in 1911 for South India, a second one was established in 1912 for North India and in 1934 a third for middle India. In 1947 the Indian Council of Nurses was formally established and immediately assumed regulatory functions leading to the opening of university-based Schools of Nursing in Delhi and Vellore in 1946 and 1947 respectively (People-Tree, 2007).

Similarly, the American influence on Filipino nursing goes back to the beginning of the 20th century during the U.S. colonial period. The U.S. established the first school of nursing in the Philippines in 1907 and has been essential in the development of the nursing profession since then. The first Filipino graduates were sent to the U.S. to undertake further studies and took academic positions after returning to the Philippines. Migration of nurses from the Philippines to the U.S. increased greatly after the establishment of an *"Exchange Visitor Programme"* in 1948 (Choy, 2003). Applications for nursing studies increased substantially as it became a good opportunity to emigrate. Permanent contact with the American health system since then has been

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strongly influential in the Filipino nursing profession. However, colonial ties clearly do not explain all migratory destination choices, as some Filipino nurses decide to go to other countries such as the UK. Understanding the reasons behind the decision to emigrate of these nurses would illuminate this relative shift from the norm.

Some cultural aspects influence the decision to emigrate. The essential concepts of purity and pollution within Hinduism render nursing poorly recognised in India by a predominantly Hindu society. Nursing, implying contact with infected substances and body fluids such as wounds, faeces or vomit, has been argued to be considered an impure activity (Percot, 2006; Thomas, 2006). Such cultural beliefs might help explain why, in a study of 448 nurses in India, 48% of the Hindu nurses expressed their intention to emigrate and 81% of her overall sample expressed being unsatisfied with Indian society's attitude towards nurses (Thomas, 2006).

Social structure in India and in particular in Kerala, where many UK IRNs are from, assigns a predominant role to male individuals. One example is the use of dowry which consists of a certain amount of money paid to the family of the groom by the bride's family before marriage (George, 2005). Boyd and Grieco (2003) suggest that the family context in the country of origin is a determinant of the likelihood for a woman to migrate as it is often in the family environment where female subordination to male authority occurs (Boyd and Grieco, 2003). The gender perspective might also have influenced the motivation of nurses not only to emigrate but also to become nurses. DiCicco-Bloom (2004) argues, in her study about racial and gendered experiences of nurses from Kerala working in the U.S., that studying nursing is sometimes the only way that women have to avoid early marriages in India (DiCicco-Bloom, 2004).

Organizational theories

Migration theories only provide insights up to the point people arrive at their migratory destination. This study however, aims at exploring how nurses settle, get adapted and whether they stay or they move forward. In order to help understand these processes, organizational theories were drawn on. Looking at recruitment and adaptation on the one hand and at retention, job satisfaction and turnover on the other helped exploring

the different factors influencing the experiences and plans of internationally recruited nurses.

Recruitment and adaptation

Available literature suggests that the process of recruitment including the process of adaptation after arrival is essential in the experience of immigrant nurses (Pilette, 1989; VOICES, 2001; Allan and Larsen, 2003; Buchan, 2003; Gerrish and Griffith, 2004). Evidence suggests that recruitment influences adaptation to the new cultural and professional environments which subsequently affects plans for career progression or intentions to stay or to leave (Wanous et al., 1992; Allan and Larsen, 2003).

As suggested by Pilette (1989) the interview or the first meeting with the employer requires a pragmatic presentation of the situation at destination, to adjust the employee's expectations to the existing reality (Pilette, 1989). Premack and Wanous (1985) found that a realistic job preview tends to lower often inflated expectations about destination countries while increasing organizational commitment, job satisfaction, performance and job survival (Premack and Wanous, 1985). Thus the early stages of the recruitment process play an important role in the development of expectations which constitute the contents of a psychological contract between employee and employer (Cavanagh, 1996; Purvis and Cropley, 2003; Guest, 2004). The psychological contract is a *"sophisticated set of expectations and rules which forms the psychological basis for the continuing commitment of employees to their employer"* (Cavanagh, 1996). Unrealistic expectations, when not met, lead to low job satisfaction and can reduce workers' intention to stay (Kotter, 1973; Porter and Steers, 1973; Guest, 2004). Wanous et al. (1992), for instance, demonstrate that met expectations are strongly related to job satisfaction (Wanous et al., 1992). These findings have been validated by others (Lee et al., 1992; Wanous et al., 1992; Fritsch, 2001; Johnson and Oldham, 2001; Buchan, 2002b; Allan and Larsen, 2003; Buchan et al., 2003).

Recruitment

Allan and Larsen (2003) suggested that the experiences of IRNs are different depending on the modality of recruitment. Overseas nurses recruitment can be active or passive.

Recruitment is passive when nurses approach employers directly. Nurses arrive in the destination country alone or as part of a family (spouses or relative of immigrants) or as refugees or asylum seekers and try to find employment (Mayor-of-London, 2002; Winkelmann-Gleed, 2006). Other modalities of passive recruitment are cited by Buchan (2003) such as application from individual nurses in country of origin or nurses working in the British private sector that move to the NHS after getting their registration with the NMC (Buchan, 2003). There are also nurses arriving in the UK as part of a travelling experience who seek employment to financially support their travel. Others come looking for a different professional experience (Allan and Larsen, 2003).

Active recruitment is referred to when employers and/or recruitment agencies on their behalf, actively seek recruitment of nurses in source countries. Within active recruitment Buchan et al. (2003) defined three modalities depending on the role played by employers and recruitment agencies. One, often used by the private sector, is when the recruitment agency assumes the leading role with minimal participation from the employer. Second is when one employer decides to recruit by itself with no involvement of agencies at all, which is rarely used in the UK context. The third and most commonly used modality in the NHS is when the employer undertakes recruitment with the support of a recruitment agency (Buchan and O'May, 1999; Buchan, 2003).

Despite their importance in nurse migration, there is little information about the operations of recruitment agencies. Connel and Stilwell (2005) in their study about the role that recruitment agencies play in international recruitment of health care professionals pointed out that they have expanded the scope and flow of health worker migration. Agencies publicise the benefits of migration and in less developed countries dominate the structure of migration (Connel and Stilwell, 2005). Buchan et al. (2005) found that 66% of the nurses participating in their study were recruited by agencies to work in the UK (Buchan et al., 2005). There is evidence of abusive³ recruitment undertaken by agencies particularly when are commissioned by private health services (Allan and Larsen, 2003; Anderson and Rogaly, 2005; Van-Eyck, 2005; Smith et al., 2006). The DoH in 2004 issued a list of agencies recommended to NHS employers for

³ The term "abusive" here refers to practices such as provision of misleading information, unrealistic promises or unfair high charges

their adherence to the Code of Practice for International Recruitment (see page 23) (DoH, 2004a).

The way in which the active recruitment process is initiated varies. As suggested by Buchan (2003), it often starts by advertising available positions in source countries, which is commonly supplemented with word of mouth information. With the increase in number and modernization of recruitment agencies, this word-of-mouth information has shifted to a means of communication more consistent with modern commercial institutions often of a global scope such as the Internet (Maybud and Wiskow, 2005). An in-country pre-selection screening is frequently undertaken by the recruitment agency. Managers from the employer then travel to source countries to interview nurses. Once selected, nurses are initially supported by the recruitment agency to start the process of registration with the NMC and to apply for work permits from the Home Office. The employer in later stages tends to take a greater role in ensuring the completion of these bureaucratic processes (Buchan, 2003).

Adaptation

Once nurses arrive at destination, a complex process of adaptation to the new environment starts. Despite the process of adjustment to the new job being perceived differently by each individual some areas are identified by scholars as common to all experiences. Ryan (2003) identified four of these areas as: socialization to the professional nursing role; acquisition of language and other communication skills; development of work-place competence both clinical and organizational; and the availability of support systems and resources within the organization (Ryan, 2003). From a socio-cultural perspective, Alaminos et al. (2003), examining the experience of immigrants in Alicante (Spain), established three main areas of acculturation: language, culture and life style (Alaminos et al., 2003).

There are different views about the cultural specificity of the nursing profession. On the one hand some scholars argue that nursing is transcultural. Flynn and Aiken (2002) and Leininger (1995) suggest that essential professional values are shared among international nurses (Leininger, 1995; Flynn and Aiken, 2002). However, some scholars highlight differences in the nursing practices and values of professionals from different

cultures (Lopez, 1990; Brush, 1999). For instance, Burner et al. (1990) identified that some black male African nurses had a slow, deliberate and perfectionist work organization that slowed completion of assignments creating problems with British colleagues (Burner et al., 1990). Nursing roles are often different in different countries. Omeri and Atkins (2002) and other scholars studied different approaches in the practice of nursing. They found that in some cultures routine care activities such as bathing and feeding patients are performed by families, while in others the nurse is expected to assume this responsibility. They also argue that immigrant nurses in Australia often prefer to undertake bedside nursing rather than a more scientific and mechanical approach involving less contact with patients (Omeri and Atkins, 2002).

The process of adjustment of IRNs to the new work environment occurs within an overall process of acculturation. Acculturation is defined by Redfield et al. (1936) as “those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in the original culture patterns of either or both groups” (Redfield et al., 1936). Berry (1997) expands this definition with regard to the extent of change. He says that it is uneven and affects one group more than the other. Often the group most affected by change is the immigrant group also called the “acculturating group”. He proposes four strategies of acculturation depending on the extent to which immigrants prefer to maintain their identity and characteristics or their readiness to interact with the native population: integration when both options are accepted; marginalisation when both are rejected; assimilation into the host culture losing their own cultural habits or segregation from the host culture in favour of their own. Most frequently the modalities found are intermediate positions and rarely one of the two extremes (Berry, 1997).

In acculturation research some scholars use a social approach and consider the group as the unit of analysis. Siegel et al. (1953) for instance argue that intercultural transmission occurs when two groups of different cultural backgrounds get in touch (Siegel et al., 1953). However other authors adopt a more individualistic approach. With a psychological perspective, Rogler (1994) suggests three factors that affect individual migration experiences: changes in socio-economic status; changes in social networks; and changes in culture, with different impact depending on gender and age of the individual under study (Rogler, 1994). In the same vein as Rogler, Olmedo (1979)

suggests that in studying migration, psychometric methods can facilitate understanding of complex issues such as the identification and cross-cultural equivalence (Olmedo, 1979). Ward's (1996) model of acculturation merges both individual and social perspectives. He incorporates both individual and societal variables as influencing the process and outcomes of acculturation (Ward, 1996). In order to achieve a broader approach to the phenomenon of migration, this study uses both perspectives and examines migrants as groups as well as individuals. For example the push and pull theory examines migrant nurses as individuals but when we look at the social factors influencing the decision to emigrate such as migratory networks, the study takes a more collectivist approach.

Adapting to the new culture is a process that follows similar patterns in most people exposed to a culture that is different from their own. Olberg coined the term "culture shock" in 1954 to refer to the problems of acculturation and adjustment of American citizens in Brazil (Shenoy, 2000). Taft (1977), revising Olberg's definition, identified culture shock as the phenomenon of immersion in a new culture as *"A feeling of impotence from the inability to deal with the environment because of unfamiliarity with cognitive aspects and role-playing skills"* (Taft, 1977). Winkelman (1994) defined four stages of culture shock including an initial honeymoon period, followed by a period of crisis characterised by rejection of the new culture and hostility towards it, then a period of adjustment, reorientation and gradual recovery. After that, she describes a period of acceptance and adaptation to the new culture (Winkelman, 1994).

Similarly Pilette (1989) found in her research about the experiences of overseas nurses recruited, adapting to work in a hospital in the USA that within the process of adjustment, there are four consecutive phases. The first phase *"of acquaintance"* represents the first contact of the nurse with the new reality and covers the period from first contacts in country of origin and the first three months after arrival. It has two different sub-phases: the first one is the *"overseas meeting"* sub-phase which occurs in the country of origin and comprises the period from the first contact of the nurse with the recruiters until departure in which expectations start to be developed. The second sub-phase is called *"post orientation"* which includes the period from arrival at destination until the end of the adaptation programme ten to twelve weeks later. In this phase overseas nurses receive much attention from supervisors and start to earn higher

wages than in their country of origin, which is normally perceived as positive. However there may be some difficult psychological experiences like the frustration experienced by senior overseas nurses when being closely supervised in their new assignments.

During the second three months at destination, the second phase "*of indignation*" is characterised by resentment, in which nurses are increasingly aware of the differences between home and destination country including working and living experiences. In this phase overseas nurses often start to see that their expectations will not be fulfilled or at least not to the extent they expected.

The third phase "*of conflict resolution*" occurs during the sixth through the ninth months in which nurses get their registration approved or not. They start to have more future orientated decision-making resulting in a more vital awareness of their future options after registration. The emotions remain intense but are more focused than in previous phases. This phase proved to be the most decisive in the retention outcome.

The last is the phase "*of integration*", when the immigrant nurse, despite maintaining some cultural integrity, shows interest in participating in the broader local social network. This phase goes from the ninth to the twelfth month and is characterised by lessened tension and renewed enthusiasm in which nurses start to have a sense of "community life" (Pilette, 1989).

The timeframes established for the different phases in Pilette's study are applicable only to the specific setting in which the study took place (U.S.), as some are prompted by the specific elements of their adaptation programme. How far they reflect experiences of overseas nurses in the UK is unknown.

Adaptation policies in the UK

Registration with the Nursing and Midwifery Council (NMC) is a requirement to practice nursing in the UK. As a requirement for application to the NMC, nurses, from February 2007, need to obtain a minimum overall score of 7 in both parts of the academic version of the International English Language Test System (IELTS). When this study took place the minimum overall score required for registration was 6.5. The NMC requires all nurses trained outside the European Economic Area to go through an

adaptation programme, the so-called Overseas Nurses Programme (ONP). In the past the programme was delivered by different organizations with great variation in standards, but from September 2005 the NMC developed a new standardized programme, which all non-EU applicants need to undertake successfully in order to get registered. The NMC issued a list of 41 Educational Institutions exclusively authorised to run the ONP. This programme aims to ensure that overseas nurses have the skills and ability to practice safely and effectively without the need for supervision. It provides the opportunity for overseas nurses to acquire the knowledge and understanding, the values, attitudes, and professional skills required to be fit for practice in the UK (NMC, 2005b). The competencies that the candidate should have achieved by the end of the programme (see annex 8) are in the areas of professional and ethical practice, care delivery, service management and personal and professional development (NMC, 2005a). There are two components of the programme. The first is a compulsory 20-day period of protected learning in which the nurse has the opportunity to understand the competences required by the NMC. In this phase the nurse is presented with the main policies affecting her work, legal aspects, organizational culture, functioning of health services and clinical aspects. The other component of the programme is the supervised practice. Not all overseas nurses have to undertake the supervised practice element, only those nominated by the NMC. It consists of a period from 12 to 24 weeks of practice under the supervision of a mentor and senior staff in the assigned ward. There is little empirical evidence about how overseas nurses view the ONP. Parry and Lipp (2006) in their study of the perceptions of 15 IRNs while going through their adaptation programme, all nurses responded positively about the course which they mentioned had helped them to better understand British nursing. However some of the nurses highlighted the fact that providing too much information during the first stages of adaptation might not be the most appropriate strategy and that continuity of the programme should be ensured through weekly or bi-weekly encounters (Parry and Lipp, 2006).

An essential element of the ONP is mentorship. Mentoring is the relationship between an experienced professional, known as a mentor, and a less experienced, aspiring person, known as mentee or protégé. The main function of the mentor is to support the mentee or protégé in her/his professional development acting as a role-model, a guide and a sponsor for her/him (Atkins and Williams, 1995). The Welsh National Board for

Nursing defined in 1992 the nature of the relationship “...a recognition of potential and a concern for the individual's well-being, advancement and general progress” (Andrews and Wallis, 1999). Although considered essential, there are some disagreements in the literature about who should be a mentor for overseas nurses under the ONP. During the consultative process undertaken by the NMC in June 2004 about the ONP for UK registration, participants suggested that NMC guidance on mentorship programmes for overseas nurses was unclear and that the standards to select mentors were inconsistent and subjective (Burke, 2004).

Rosser and King (2006) suggest that besides language, new culture or new working environment, shifting from a curative model to a care-based model was among the most challenging adaptations that Filipino nurses had to experience when working in a hospice environment. Lack of recognition of their skills by colleagues and superiors was one of the major sources of frustration for this group of nurses. The mentorship element was perceived as weak due to lack of preparation of mentors about the specificities of mentoring IRNs (Rosser and King, 2006).

There is evidence in the literature of discrimination against migrant nurses which constitutes a major barrier for adaptation. Pudney and Shields (1999) documented gender and racial discrimination in pay and promotion for NHS nurses. The main findings of their study show that career progression among female nurses is slower than among male colleagues and also that there is an economic advantage for white over black and Asian nurses (Pudney and Shields, 1999). A study of the perception of discrimination and racism among overseas nurses working in the UK suggested that institutional racism is reproduced through interpersonal and social relationships (Allan et al., 2004). Withers and Snowball (2003), in their study of the adaptation of Filipino nurses to a NHS Trust in Oxford, also found that some of the participants experienced what they perceived as racial discrimination from patients and colleagues (Withers and Snowball, 2003). Daniel et al. (2001) argue that there is a need to monitor the performance of Filipino nurses in the long-run as some barriers for career progression were found to be unfairly hindering their advancement (Daniel et al., 2001). As suggested by DiCicco-Bloom (2004) discrimination is the result of an intertwined mix of gender and race based attitudes that result in career stagnation and unfair treatment by peers and managers (DiCicco-Bloom, 2004).

Career advancement among overseas nurses is an essential factor for work motivation and job satisfaction that given the limited information available needs further exploration. Scholars found that previous professional experience of overseas nurses is often not recognised in the UK and that they are assigned positions below what it would have been expected according to their year of graduation, educational qualifications and professional experience. They also found that the system for career promotion was not transparent and often left overseas nurses at a disadvantage. They argue that this can promote an environment that facilitates discrimination (Sheffield et al., 1999; Allan and Larsen, 2003; Kline, 2003; Alexis and Vydelingum, 2004; Smith et al., 2006).

Retention, job satisfaction and turnover

The concepts of retention and turnover are two facets of the same phenomenon. Job satisfaction and dissatisfaction are often mentioned in the literature as the interface between them. There is considerable consensus that satisfied nurses have less intention to leave a job (Irvine and Evans, 1995; Cavanagh and Coffin, 1999; Yin and Yang, 2002).

Retention

Increasing retention was one of the strategies adopted by the NHS in the UK to tackle the shortage of nursing staff in 2000 (NHS, 2000). However, empirical evidence on the retention of nurses is limited. Economic, professional and personal factors are the most frequently argued. At economic level, incentives, both economic and non-economic are often mentioned as an important factor retaining health professionals (Bhattacharyya et al., 2001; Hicks and Adams, 2002; Hongoro and Normand, 2006) and more specifically nurses (Kingma, 2003). However financial incentives have different impact on retention depending of the overall economic situation of the country. There is some evidence about factors favouring retention among the general nursing population. However, evidence is less available about overseas nurses. Some authors approach the problem from a social perspective. They suggest that developing social and cultural bonds with the recipient country increase the likelihood of overseas nurses to remain at the destination country longer than if they do not (Padarath et al., 2004). From a more

professional and labour perspective other authors suggest that promoting diversity among local nurses, supporting continuous education and valuing overseas nurses contribute to retain overseas nurses (Alexis, 2002).

Job satisfaction

The term job satisfaction is central to this research and needs to be clearly defined. It is important to differentiate terms such as job satisfaction and work motivation, which despite their different meaning, are often used interchangeably. Motivation is defined as a conscious decision to perform one or more activities with greater effort than other competing activities (Cook et al., 1997) or as the willingness to maintain an effort to achieve an organizational goal (Franco et al., 2002). Scholars defined job satisfaction as the affective orientation or the feelings that an employee has towards her or his work (Price, 2001; Lu et al., 2005). Other scholars use needs as the base to define satisfaction. Maslow (1987) defined satisfaction according to a hierarchy of needs. He suggests that motivation leads human beings to apply effort to achieve lower level needs that once satisfied trigger the perception of higher level needs (Maslow, 1987). Alderfer (1972) refused to accept that it is necessary to cover basic needs to achieve higher needs. He established the so-called “ERG theory” based on the motivation to cover “Existence” needs (basic survival needs including psychological and safety needs), “Relatedness” needs (interpersonal contacts) and “Growth” needs (personal development and self-worth) (Alderfer 1972) cited in (Cook et al., 1997). Herzberg and Mausner (1959) found that satisfaction and dissatisfaction are two different phenomena and that both are influenced by different factors. This dual theory of job satisfaction identified factors (motivator factors) such as job challenge, responsibility, opportunity for advancement and recognition that by being present produce satisfaction. They also identified other job factors (hygienic factors) such as job security, working conditions, quality of supervision, interpersonal relationships and adequate pay that if lacking can cause dissatisfaction but which presence does not necessarily produce satisfaction (Herzberg and Mausner, 1959). Other scholars base their theories on the outcomes of the process rather than on the process leading to satisfaction. The most important among them is the Expectancy Theory of Victor Vroom (1995) in which he demonstrates that human beings’ motivation to work depends on the one hand on the value (valence) that the

person assigns to the outcome expected from working and on the other hand on the value of the outcomes from not working (Vroom, 1995).

Some factors related to job satisfaction in nursing are well identified in the literature. There is a strong relationship between job stress, organizational commitment and the cohesion of the nursing team and the level of job satisfaction (Packard and Motowidlo, 1987; Blegen, 1993; Knoop, 1995; Adams and Bond, 2000; Fang, 2001). There is a moderate relationship between satisfaction and professional commitment, interaction with physicians, recognition, fairness, communication with managers and colleagues and supervisor's support (Packard and Motowidlo, 1987; Knoop, 1995; Adams and Bond, 2000; Fang, 2001; Chu et al., 2003).

Factors found to contribute to job satisfaction and hence to improve the likelihood of remaining in the job include on the one hand pay, benefits and working schedules. On the other hand organizational and peer support and contact with patients, particularly when dealing with patient's feelings (emotional labour) have been also found to increase retention (Zeytinoglu and Denton, 2005).

Despite evidence of factors influencing the motivation to work and job satisfaction of nurses, empirical evidence derived from specific studies about overseas nurses is unavailable. The specific characteristics and motivation of these nurses might differ substantially from those of local nurses. However, we know why overseas nurses come to the UK, what make them decide to leave their countries and what they expect to find in the UK. Pull factors identified as attracting overseas nurses to the UK reflect their expectations which if met are likely to increase their job satisfaction. Push factors could give an idea of those elements that generate dissatisfaction among these nurses.

Turnover

The definition of turnover is not consistent across available literature, which makes it difficult to compare or generalize across different studies (Hayes et al., 2006). Some scholars look at turnover from a professional perspective (leavers vs. non leavers) while others look at it from a more organizational perspective (intention to quit vs. intention to stay) or institutional viewpoint (vacant positions vs. filled positions) (Tai et al., 1998).

Jones (1990) defined nurse turnover as “the process whereby nurses leave or transfer within the hospital environment” (Jones, 1990). Finlayson et al. (2002) define staff turnover as the number of nursing staff who leave a post and move on to another NHS organisation or who are known to have left the NHS altogether, over one year (Finlayson et al., 2002). This last definition was found adequate for this study about nurses working in a decentralised organization such as a NHS Trust where hospitals and even wards within the same hospital compete for resources. From the employer perspective, apart of the turnover, it is important to know the wastage. The wastage refers to nurses leaving the NHS as a proportion of staff in post (OME, 2006).

Nurse turnover affects negatively health services by weakening their capacity to deliver quality health care (Tai et al., 1998). The gap left by the outgoing nurse, the recruitment and initial low level of productivity of her replacement and the negative impact on co-workers reduce the cost-effectiveness of nursing care (Phillips, 1990). Turnover also affects the morale and productivity of the rest of the nursing workforce as they assume the extra work while new staff are hired and oriented (Cavanagh and Coffin, 1999). But turnover is also positive in some aspects. Renewal of the nursing workforce is needed. New nurses cost less than experienced nurses as they get lower salaries and fewer benefits than nurses that have been in the organization for long time (Jones, 1990a). When turnover is not resulting in wastage (nurse leaving the profession) but just moving from one ward or organization to another, there is a potential increase in productivity due to the nurse being better motivated to perform (Gray et al., 1996)

A study undertaken in several OECD countries found that turnover rates among nurses were between 9% and 15% (Simocens et al., 2005). In England and Wales turnover among nurses working for the NHS in 2005 was 10.5% and the wastage was 8.4%. In Inner London there is 13.4% turnover and 11.4% wastage (OME, 2006). These figures represent a substantial improvement if we compare them with those found by Finlayson et al. (2002) in 2000 where 25 out of the 33 acute Trusts in London had above 20% turnover, 18 had more than 25% and 9 more than 30%. Teaching Trusts located in Inner London as the one under study in this research had the highest turnover rates in the UK (Finlayson et al., 2002). Problems of low retention among health workers in London were attributed to, among other factors, high workloads and high cost of living in the capital (Hutt and Buchan, 2005).

Reported turnover and wastage among nurses in the UK were similar to that in other comparable professional groups. National figures of turnover and wastage among teachers is 13.2% and 8.2% respectively while in London it is around 14% and 9.6% respectively (Smithers and Robinson, 2004).

Data about turnover of IRNs in the Trust under study shows that of 354 nurses internationally recruited during the years 2000-2005, 54 had resigned by October 2006. This represents a 14.2% of the cohort recruited in that period. However, it is difficult to know the relative importance of these data as, being sensitive information, there is no reference in the literature about the performance of other Trusts in this regard for comparison.

Organizational, individual and economic factors are the most cited determinants of turnover among nurses. Among the organizational factors the most commonly reported by researchers are workload, management style, autonomy, career opportunities and work schedules (Hayes et al., 2006).

The interface

Mueller and Price (1990) defined a model of nurse turnover behaviour. It defined the relationship between economic, structural and psychological variables and nurse job satisfaction which in turn is related to behavioural intentions of turnover (intention to stay or to leave) which was found to be strongly related to turnover behaviour (Mueller and Price, 1990).

An important implication is that job satisfaction is a determinant of intention to stay or to leave rather than of actual turnover. Nurses first develop an intention to leave which eventually ends in actual turnover (Irvine and Evans, 1995). Thus policies aimed to increase job satisfaction are likely to have an impact on turnover and retention.

Chapter summary

There is not much literature available about the experiences and plans of internationally recruited nurses in the UK. Much of the quantitative literature available reflects on

analysis of secondary data from institutions such as the Nursing and Midwifery Council (NMC) or the Office of Manpower Economics (OME), which are often incomplete. While information on the British nursing labour market is relatively available, specific data on overseas nurses is often not easy to disaggregate from the general data. Nevertheless the available quantitative literature reports that the British health system relies on overseas nurses to fill its gaps in the nursing workforce. Analysis of the nursing labour market indicates that the UK will continue having to recruit nurses internationally to meet increasing demand. Qualitative research on the experiences and the specific problems of overseas nurses is scarcer. Several studies have drawn on empirical data to illuminate the experiences of this group of nurses and have found that nurses come to the UK for different reasons including but not exclusively economic improvements. Some studies have provided insights on the motivation and plans of IRNs, but a few in the nurses' own words.

In reviewing the literature it was found that one theory of migration would not help to understand the issue of internationally recruited nurses, their motivations for migrating, their adaptation to the new environment and whether they plan to stay or to move somewhere else. This study has therefore drawn on several theoretical approaches. From the body of migration theory this study applies concepts such as pull and push factors together with some insights on social and cultural factors associated with the phenomenon of migration more specific to the nursing context of this study. To provide insights into workplace adaptation the study uses concepts from the organizational literature on recruitment and retention, job satisfaction and turnover.

Chapter 2: Methodology

Research purpose, objectives and questions

Research purpose

The overall purpose of this research is to improve understanding of the recruitment and retention of overseas nurses in the UK, in particular those recruited internationally. As the literature review demonstrated, little is known about their expectations about living and working as a nurse in the UK, their experiences during the processes of recruitment and adaptation to the new environment and their plans for the future. This study was designed to explore these issues with regard to a particular group of nurses migrating to London from India and the Philippines.

Research objectives

The objectives of this study arose from the professional interests of the researcher, knowledge gaps in the literature and the interest of one particular London Hospital Trust in understanding IRNs and their career progression plans. Specific objectives were:

1. To understand the factors motivating IRNs to migrate to the UK and to explore the decision-making process involved.
2. To describe the process of international nurse recruitment in the NHS and to explore the experiences of the nurses under study
3. To understand the nature of and explore nurses' experiences during the process of adaptation to the UK environment.
4. To explore how IRN expectations about the UK develop and how those change along the process of adaptation, with special emphasis on career advancement and professional development
5. To understand the initial future plans of these nurses and explore how these plans change along the process of adaptation.
6. To provide recommendations based on findings to contribute to improving the experience of IRNs and their retention in the NHS

Research questions

In order to help the process of inquiry and in line with the research purpose and objectives some questions were formulated corresponding to each of the areas of study as shown in Table 5.

Table 4 Research areas and questions

AREA	QUESTIONS
1.- The decision to emigrate	What factors in their country push these nurses to make the decision to emigrate?
	What attracts them to the UK?
	What role did different actors involved in the decision-process play?
	How did IRNs select their country of destination?
2.- The process of recruitment	What is the policy for international recruitment in the UK?
	How was the recruitment process handled in the Trust?
	What are the experiences of IRNs concerning the recruitment process?
	What are the views of the employer about the process of recruitment?
	What are the implications of the recruitment process in terms of job satisfaction and retention?
3.- The process of adaptation	What are the experiences of IRNs during the process of adaptation?
	What are the main areas of adaptation to the new environment?
	What is the nature of the ONP and how is it handled in the Trust?
	How do IRNs cope and describe their experiences? To what extent does the programme respond to IRN perceived needs?
	What else can the Trust do to facilitate and support this process?
	What are the implications of the adaptation process in terms of job satisfaction and retention?
4.- Expectations and experiences	What are the expectations of IRNs?
	How and when are these expectations developed? Are they met?
	Do expectations change along the process of adaptation?
	What are the specific expectations of IRNs about professional development and career progression?
	What are the implications in terms of job satisfaction and retention?
5.- Future plans of IRNs	What are the future plans of IRNs?
	How long are they planning to stay?
	If they leave, why do they plan to leave?
	If they leave, when do they plan to go?
	If they leave, where do they plan to go?

Theoretical framework

The different theories and concepts considered for this study about nurse migration presented in chapter one, constitute the framework for this study, by building on elements that helped to explore some of the little understood aspects of migration, such as the motivation to emigrate, nurse expectations and experiences. The main theoretical perspectives were derived from migration theory (push and pull factors and

acculturation theory) and organizational theory (adaptation, job satisfaction, retention and turnover). It is important to acknowledge the fact that using this theoretical approach was just one choice and that having looked at the issue from other perspectives such as psychology, economics or gender would have produced different findings.

Research approach

Given that a major aim was to understand nurses' experiences this study took an interpretative approach. This approach is based on the complex nature of human behaviour in which the aim of research is to facilitate its understanding (Green and Thorogood, 2004) and implies that meaningful understanding of human behaviour emerges through interaction in which accounts are analysed as research data (Hammersley and Atkinson, 1983). Hence this study explores nurses' views within the context in which their experiences are occurring, allowing for deep understanding of their meaning.

One of the strategies and strengths of this study is that it gives voice to the nurses. In order to produce accounts that are representative of what nurses perceive, the researcher had to move between two different positions. By talking to these nurses in-depth about their views, the researcher entered in their world and looked at it with the eyes of the nurses, getting an empathic understanding of the nurses' perceptions and producing accounts about their experiences that are faithful to their perspectives. However at times the researcher positioned himself in the role of an outsider from where he was able to make sense of the local reality and how people made sense of it. Social scientists define the perspective of the "insider" as the "*emic*" perspective and that of the "outsider" as the "*etic*" perspective and suggest that this tension between the "*etic*" and the "*emic*" perspectives drives the ethnographic analysis (Green and Thorogood, 2004). Hence the study aims to understand what the experience of migration means for the nurses themselves (Denzin and Lincoln, 1994). Although some studies have quantified the extent of nurse migration and the different flows of nursing professionals across countries, the knowledge about the nature of this phenomenon is limited. Understanding nurse migration from the perspective of the nurses requires an in depth exploration of

issues such as their motivation to emigrate, their expectations about the country of destination or their experiences during the process of migrating and adapting to the new environment.

The study is mostly based on inductive reasoning, moving from specific issues towards broader generalizations. However, the process of analysis of data was recurrent and iterative and inevitably led to some deductive processes when emerging patterns and hypotheses led to further confirmation and validation during subsequent revisits to data.

Research design

A case study design was deemed to be the best method of producing an in-depth understanding of this complex phenomenon from the nurses' perspective. It is a study focussed on one specific scenario -a group of nurses from India and the Philippines working in a National Health Service (NHS) acute Trust in London. *"A case study is an empirical enquiry that investigates a contemporary phenomenon within its real-life context"* (Yin, 2003). Its flexibility allows exploration of unknown issues as they emerge rather than other more prescriptive study designs which require more predictability in terms of the expected results (Becker et al., 2005).

One of the main criticisms of case study design is that they are specific for place and time, and lack generalisability (Yin, 2003). However generalisability is not the aim of this study but rather the deep understanding of this specific case. Lincoln and Guba (1985) when defining the concept of "fittingness" suggest that theories built about one context may be applicable to a similar one (Lincoln and Guba, 1985). In this case, the fact that some of the findings are similar to those undertaken in similar environments such as Daniel et al. (2001), Withers and Snowball (2003), Allan and Larsen (2003), Parry and Lypp (2006), Rosser and King (2006), Smith et al (2006) or Buchan et al (2006), may indicate that the results could be relevant to other similar contexts. However, findings of this case study may be generalisable to some broader theory (Yin, 1994) based on identification of some principles concerning the migration phenomenon rather than upon the *"typicality of the sample in relation to a parent population"* (Sharp, 1998).

The research has two main elements. First, a longitudinal study following a group of six Indian nurses actively recruited by the Trust, from their arrival in London in February 2005 over the next eight months. This element includes interviewing nurse managers and mentors of these nurses. The second element involves a cross-sectional study of two groups of six and nine Filipino nurses respectively recruited by the Trust around one and four years before this research was initiated. The longitudinal element of the design helped to solve some of the problems that could have arisen from the sample (see below). The researcher, being a male may have influenced the responses of IRNs who were all women. They might have preferred not to speak about certain issues with a man and may have hidden perspectives of their experiences that could have contributed to an improved understanding of the issues under study. However the fact that there was a relatively long engagement with some of the nurses, involving several encounters over a relatively extended period of time, might have also given more confidence to the participants to speak with the researcher about some issues that would not have otherwise been disclosed.

The richness of the data obtained with this study design constitutes one of the strengths of the study, which allowed an in-depth understanding of the phenomenon of migration of IRNs from India and the Philippines.

Research site

London was selected because the proportion of international nurses is greater than anywhere else in the country (Buchan, 2003). The specific NHS acute Trust was selected as the research site essentially because it had a history of international recruitment over four years, it was actively recruiting overseas nurses at the moment of data collection and also because access was obtained from the management. The Trust comprises three teaching hospitals offering services to more than 2.5 million people, with more than 1,000 beds and more than 7,000 staff, of whom between 1,800 and 2,000 are nurses. These include 203 IRNs mainly from India and the Philippines when the study began in February 2005. In October 2006 the number of IRNs was 323.

Sample and access

Sample

Participants for this study were purposively sampled. The objective of purposive sampling is to select “information-rich cases for in-depth study” from whom one can learn issues that are central to the purpose of the research (Patton, 2002).

Purposive sampling is commonly driven by previous knowledge or theory (Pope and Mays, 2000) and/or by initial data collection. Based on acculturation theory and existing empirical evidence about the relative impact of the adaptation process of new employees on their experiences and motivation (Wanous et al., 1992; Winkelman, 1994; Berry, 1997; Gerrish and Griffith, 2004), the researcher looked for groups of nurses with different length of experience in the UK. In particular, Pilette’s (1989) findings about the process of adaptation of international nurses aided the selection of participants (Pilette, 1989) such as the different stages of early adaptation that overseas nurses experience. Other criteria deemed to be potentially important were: previous professional experience; previous migratory experience; and professional experience in the UK.

The Trust, following Data Protection regulations, assigned one person in the Department of Recruitment & Retention (R&R) to deal with the researcher for recruitment of participants. That person followed criteria provided by the researcher and contacted potential participants, giving the contact details of those agreeing to participate to the researcher.

This purposive sampling included four groups:

- Group A comprised 6 newly recruited nurses from India selected from a group of sixteen that were being recruited by the Trust. Three interviews with each nurse at different stages of their initial adaptation were planned: upon arrival; 2 months later; and 8 months later.
- Group B comprised 6 nurses from the Philippines arrived in the UK around one and a half years before who had registered with the NMC and had had some months’ work experience as registered nurses in the UK.

- Group C initially comprised 8 overseas nurses from the Philippines arrived around four and a half years before in the UK with around four years experience after registration with the Nursing and Midwifery Council. This group was divided into two subgroups according to their professional grade: 4 nurses were holding a junior professional grade (D grade) and 4 more senior positions. The split of this group in two sub-groups aimed at allowing for comparison of their experience of career progression and for improving understanding of the reasons that led some of them to assume managerial responsibilities while the rest had not progressed. After preliminary analysis of the data obtained from interviews with the second sub-group comprising nurses holding mid-level management positions (E and F grades), it was decided that one more nurse in a more senior position could add comparability and new perspectives to the sample and another Filipina in an H grade position was recruited.
- Group D: In order to gain a more comprehensive view of the IRNs' experiences and expectations the perspective of the employer was sought. Four ward sisters and four adaptation mentors, from those in charge of nurses in group A, were recruited finally. In order to have more information about the recruitment process from an employer's perspective, two hospital managers who travelled to India and the Philippines for the selection of some of the nurses were recruited.

Sample size was decided according to estimates of what could be needed for saturation based on other similar studies. Initially 5 participants for group A, 5 for group B and 8 for group C (4 for each sub-group) were thought to be enough. Later one more nurse was added to each group in order to cover possible withdrawals. One extra nurse was added to the sub-group of senior nurses in group C. After the first interview with the group of Indian nurses (A), two withdrew and one was recruited whom was justified by the initial plan of working with five in each group. During the third round of interviews with this group, one of the nurses was on long-term sick leave and could not be interviewed.

Table 5 Interview sample

Interviews	A	B	C		D			TOTAL
			D grade	Above D	Mentors	Managers	Rec.Mgrs.	
1 st	6	6	4	5	4	4	2	n=32
2 nd	5							lws=40
3 rd	4							

Therefore the sample comprised three groups of overseas nurses in different phases of adaptation and one group of nurse managers and mentors. All the IRNs in this research were women. There were only two men who were mentoring two of the Indian nurses in the sample. More demographic information about each participant can be found in Annex 10.

Access

The procedure for recruitment of participants was fully compliant with the regulations established by the Research Ethics Committee of the Trust. The researcher, due to Data Protection requirements was not allowed to contact potential participants directly.

Group A: the Recruitment & Retention Department in the Trust (R&R) sent an information sheet (Annex 1) to 16 nurses being recruited from India before their departure. On the day of their arrival in London, during the course of an induction session, the researcher gave a presentation of the research plan, emphasising his independent status from the Trust and the freedom of nurses to choose to participate or not without fearing any reprisal from the Trust. All nurses (16) expressed their willingness to participate in the study. After the presentation, nurses were provided with a form requesting information about their age, previous migratory experience and overall professional experience. The analysis of that information was undertaken while they went for a visit to the surroundings of the hall of residence where they were accommodated by the Trust. Six nurses were selected out of 16 willing to participate allowing for maximum variation of previous professional experience in nursing and previous experience of migration. In order to ensure good recall of the recruitment

experience and to minimize changes in their expectations due to first impressions, the initial interviews with these six nurses were arranged for the following two days.

Groups B and C: The charge nurse from the R&R Department identified potential candidates for these groups. A research information sheet was sent to all of them. From those who agreed to participate, the R&R charge nurse, following the established selection criteria, selected 6 nurses working in the same ward for group B and 8 working in different wards for group C and provided their contact details to the researcher. Having group B composed of nurses working in the same ward was initially perceived as a potential weakness but later it was considered as an opportunity to allow exploration about the influence of ward management over the experiences of IRNs. The researcher got in touch with these nurses and the best time and venue for interviews were agreed with them.

Group D: The process of recruitment of mentors and managers, including the two recruitment managers was fully managed by the R&R Department. Potential participants were sent an information sheet and their contact details were given to the researcher who then managed the arrangements to interview them.

The fact that the researcher had limited freedom to select participants might have had some influence over the study. The researcher was able to decide which Indian nurses from the group of 16 were to be selected as participants for the study (see criteria on page 52). With Filipino nurses, the pre-selection was undertaken by the Trust using the criteria provided by the researcher. The fact that the Trust was very interested in understanding some issues such as the reasons behind the apparent stagnation of Filipino nurses in their career progression can be considered as strength but also might have influenced the selection of nurses. However, the researcher gave clear criteria about this specific group trying to get four nurses holding a D grade position and four holding positions above that. Also the fact that the Trust is interested in showing good retention and good practice for recruitment might also have influenced the selection process, selecting nurses likely to provide a positive feedback about their experience. The Trust might have avoided including in the pool of participants nurses known to have had a negative experience during their recruitment or adaptation or any nurse from cohorts in which the process is known for not having worked well in this regard.

Data collection methods

The purpose of the research, the research questions and objectives, the context in which it was undertaken (DrPH) and time and financial limitations guided the choice of methods to be used.

Interviews

In exploring a relatively unknown issue such as nurse migration, the methods chosen needed to allow enough flexibility to shift the focus towards new emerging issues if required. Interviews were found best suited to fulfil that criterion. Interviews are the most commonly used method in qualitative health research (Green and Thorogood, 2004) and aim to discover the interviewee's own framework of meanings (Britten, 2000). Interviews can be undertaken in groups or individually. Among the few qualitative studies available about nurse migration, group interviews were most frequently selected as the method of choice (Daniel et al., 2001; Allan and Larsen, 2003; Allan et al., 2004; Gerrish and Griffith, 2004; Larsen et al., 2005). Some of these acknowledge that in order to obtain more in-depth information, individual interviewing would be more appropriate (Larsen et al., 2005). Trying to explore personal experiences covering sensitive issues in detail such as frustrations or future plans, might have been difficult for some nurses to discuss in a group setting (Kvale, 1996). Thus a decision was made to undertake individual interviews as the method of choice for data collection.

For this study semi-structured interviews were deemed to be the best choice given that, on the one hand, the flexibility of this method matched the aim of the study to improve understanding about a relatively unknown phenomenon likely to generate new issues while talking to nurses about it and, on the other hand allowed for exploration of the main themes identified in the literature review. Interview protocols were prepared for each group and used as a guide for the interview (see annex 9).

Reflexive diary

The reflexive diary contains the description of what the researcher observed and experienced. It allowed him to go back to recall and experience memories, not only of

descriptions of the specific context in which the interview took place, but also of feelings and reactions to the experience, and reflections about the personal meaning and significance of what was observed (Patton, 2002). Reflections about the researcher's encounters with nurses, or reflections of the researcher about the perceived impact of the encounters on the interviewee, were annotated after each interview in the reflexive diary. The diary included notes about the place where the interview took place, observations about the physical work environment, or methodological issues found during the process of interviewing, transcribing or analysing data. Emotions perceived during interviews were also recorded. This information helped the researcher to recall non-recorded issues such as body language or any other element of non-verbal communication.

Documentary review

In qualitative research, the context in which research takes place is of paramount importance. In order to understand the context in which this study was undertaken, a documentary review was performed. Documents are products of structured and informed social practices deriving from the decisions which people make as individuals and members of groups or organizations (May, 1997). Documents can help to understand situations or decisions taken in the past in a given context. Documents can be used as data or as means of verification (Finnegan, 1996). In this research documents reviewed included policy documents related to nurse migration, reports about the situation of the nursing labour market, guidelines about the process of recruitment, reports from the different institutions dealing with registration and licensing, newspaper articles and documents related to the ONP. The Internet was also used for contextual documentation such as web sites specialising in recruitment of overseas nurses or associations of migrant nurses.

Data collection procedures

Interviews

Interviews in this study were undertaken as a face-to-face conversation. The researcher contacted Ward sisters in charge of the participants some days before the interview to

confirm their agreement about interviewing nurses during their working time, and to ensure availability of an appropriate room for a private interview. All interviews were recorded with prior written consent from the interviewees (see annex 2). The average duration was one hour. All interviews were undertaken in English. At the end of each interview some demographic information about the participant was gathered and recorded in a data entry form. The first and second interviews of Indian nurses occurred in a private room at their hall of residence. The rest of the interviews took place in a room at the nurses' workplace where privacy was ensured: a classroom within the ward, a store or an office.

Despite having tried to ensure a quiet place for the interviews, the fact that most took place at nurses' workplace while they were on duty, caused some interruptions (in a quarter of the interviews with the nurses and mentors and in almost all the interviews with managers). When this occurred, recording was stopped and an explanatory note inserted in the transcription. The impact of the interruption on the interview process, which usually was minimal, was recorded in the reflexive diary.

All first interviews of nurses in group "A" took place within two days of their arrival in February 2005. The second interviews with this group took place in April 2005, around six weeks after the completion of the induction programme when they had been in the UK for two months. The final interviews were undertaken in October 2005 when all nurses had completed their ONP, were registered with the NMC and had been in the UK for eight months. The two groups of Filipina nurses with one and a half and four years experience in the UK respectively and the group of mentors and managers were interviewed in March and April 2005. The two managers involved in recruitment were interviewed in September 2006.

Two nurses from group "A" withdrew from the study after the first interview. The researcher, despite having tried to contact them, could not get information about their decision to withdraw. After their withdrawal, one more nurse from the same cohort was recruited. The first interview with this nurse covered topics from the first and second interview protocols. After having been interviewed for a second time one other nurse withdrew from the study due to illness. Thus, from the group of Indian nurses, three

were interviewed three consecutive times, two were interviewed twice and two were interviewed only once. In total six first interviews, five second interviews (one modified to cover 1st and 2nd) and four third interviews were carried out with this group.

Data entry and organization

Recorded data were transcribed verbatim using Microsoft Word® by the researcher and transferred to *Nud*ist 2003-2005 Qualitative Research Software Solutions, QRS International Pty. Ltd., Victoria*. The software was used essentially to facilitate the analysis but it constituted a good tool for filing and retrieving text.

Data analysis

Approach to analysis

The aim of the research element of a Doctorate in Public Health is to generate evidence for policy making to improve public health practice (LSHTM, 2006). For this purpose, Green and Thorogood (2004) suggest that the framework approach to analysis of qualitative data is relevant. The framework approach uses the research objectives as a guide to support the analysis. The process starts with *familiarisation* – i.e. listening to all interviews and identifying key ideas and recurrent themes. The process continues with an identification of a thematic framework drawing on *a priori* issues and issues emerging from the initial analysis (*thematic analysis*). Subsequently, the list of themes identified in the previous stage is applied to all the data, allowing for intra and cross case comparison. The next stage is to rearrange the data according to its thematic content either case by case or by theme, with a short summary referenced to the original transcript allowing for comparison across each code, identifying where phenomena occur or not and looking for relationships between codes (*charting*). The last phase involves looking for relationships and associations between concepts and typologies derived from them (*mapping and interpretation*). One of the strengths of the framework approach is that the integrity of the respondent's accounts is kept throughout the analysis, as opposed to other strategies such as Grounded Theory that tend to fragment the data, regardless of the individual source, to construct new areas of exploration (Green and Thorogood, 2004).

Method of analysis

The study design allowed for intra case as well as cross case analysis. Keeping the integrity of the participants' accounts during the analysis was important for some objectives of this research, particularly those that focus on the progressive change of expectations and plans along the process of adaptation. Intra-case comparison was undertaken by contrasting the individual Indian nurses in different stages of their migratory experience and adaptation. Cross case analysis was undertaken by contrasting nurses with different lengths of experiences in the UK; comparing participants with previous migratory experience with others coming to the UK as their first experience of migration, and also Indian with Filipina nurses. Initially it was thought that by having three groups with different lengths of experience in the UK would inform the process of adaptation. Later it was found that being the first group from India and the second and third groups from the Philippines were not as easily comparable as anticipated. Indian and Filipina nurses were found to have considerable differences in terms of motivations, perspectives and attitudes, which had an influence over their experiences. Therefore exploration of the process of adaptation was done separately for Indian nurses during their first eight months and then for Filipina nurses during the period from their first to their fourth year.

Process of analysis

The process of data collection and analysis overlapped. First all interviews were listened while reading the transcriptions for validation, detection of nuances and transcription errors. This first reading was helpful for familiarisation with the data. Listening to each interview again followed by reading the transcription allowed for an initial analysis allowing for identification of some themes that were incorporated in subsequent interviews. Notes taken in the reflexive diary were read before listening to each interview to enrich the contextual recall during the audition but were not included as data in the formal analysis. Three initial themes generated during the literature review were established *a priori*: i.e. "expectations", "experiences" and "future plans". All the data sets were checked against these three main themes using the software. Units of data were assigned to each category or, if not found related to any of the initial three, put

under a new category. New categories such as “language”, “mentorship”, “uncertainty” and “peer support” or “reasons to emigrate” and “decision making process” were grouped under new categories such as “adaptation” or “decision to emigrate”. Repeating this process for any new theme emerging from the data was the next step until no new themes emerged.

Themes and categories were then analysed looking for inter-relationships between them and grouped accordingly. Some of the categories were displayed in charts keeping individuals from the same group together allowing for comparison between individuals and groups (see annex 3). Some of the themes such as “culture shock” were then reviewed within relevant literature aiding the process of conceptualisation and understanding.

In identifying patterns within the data and due to the small size of the different groups, the researcher felt that using numbers could be misleading and preferred instead to use quantifiers such as, “few”, “some”, “many” or “most” which are consistently applied across this thesis.

Ethical issues

Ethical clearance was obtained from the Research Ethics Committee of the relevant London Strategic Health Authority and from the Ethics Committee of the London School of Hygiene and Tropical Medicine (see annexes 4 and 6). After consideration of the potential local impact of the study, permission to undertake the study and proceed with the data collection was obtained from the Office of Research and Development in the Trust where the study took place (see annex 5). These processes were often long and sometimes frustrating due to delays and bureaucratic procedures. One of the main concerns was that application requirements and forms were standardised for quantitative studies (mostly clinical experiments) and not adapted for a study undertaken with a naturalistic qualitative approach. However the comments received from both institutions helped the researcher to get new perspectives and ideas for the design of the study that is thought to have contributed to improve its quality.

Every participant was informed of the nature and objectives of the research prior to their selection. Having been approached by the Trust R&R Department, some of the nurses - particularly those newly recruited- could have felt an obligation to participate in the study. In the briefing document provided to all potential participants (see annex 1), it was clearly stated that the study was undertaken by an independent researcher as part of a research degree and that participants were free to get involved or not without fears of any reprisal from the Trust. For the group of Indian nurses, specific emphasis was placed on this. It was also reiterated that the findings would be written up as a thesis, parts of which might be published in scientific journals and that confidentiality and anonymity would be ensured at every stage of the process.

Before starting each interview, issues about confidentiality and freedom of choice of participation were again reiterated to each participant. They were all requested to sign an informed consent form (see annex 2). Interviews were all undertaken in a space where privacy could be ensured. The key for identification of the anonymised identity codes with the original names of the participants was only accessible to the researcher; All material containing data or sensitive material was kept at all times under lock and key. Transcriptions shared with supervisors and peer research students during the process of analysis contained only anonymised codes and were previously cleaned of any information susceptible to disclose identities. Codes included in the audio records provided to the transcription assistant were all changed after completion. All the names included in this thesis have been changed to protect identities.

The codes used for identification of each participant contained information about the selection criteria. All codes have the format ID/F1.1/15.7mUK/YesOSExp in which the first ID means identification, the second space inform about the nationality (F or Id) and the group (group 1 refers to group B and group 2 refers to group C) and a number indicating the order in which nurses were interviewed within the same group (1.1 indicates the first nurse interviewed from group B). The next space inform about the time since the nurse arrived in the UK at the time of the interview in months (except for the first interview with Indian nurses which is expressed in days). The last item of the code inform about the previous overseas experience (YesOSExp or NoOSExp).

The Research Ethics Committee of the Trust suggested the researcher needed to be aware that the nurses might confide in him during interviews about sensitive issues such as bullying or discrimination. It was agreed that the researcher would refer any interviewee to information and policies of the Trust in this regard, which was only required once.

Rigour

Rigour, as suggested by Green and Thorogood (2004), refers to the credibility of the analysis and the faith in its reliability and validity. They propose some criteria to define rigour in qualitative analysis such as transparency, validity, reliability, reflexivity and comparability.

Transparency refers to the explicitness about the methods used and processes followed (Green and Thorogood, 2004). In this study, the researcher has presented clearly the procedures followed for sampling, collecting and analysing the data and presenting the results. The use of software to support the analysis enhanced transparency of the process (Bringer et al., 2004).

Validity in qualitative research refers to the extent to which the report of the interpretation of its results, represents the phenomena that it purports to represent, in essence the “truth” (Silverman, 2002). Lincoln and Guba (1985) consider respondent validation as the strongest check on credibility that a study can get (Lincoln and Guba, 1985). Respondent validation consists of presenting the findings of a study to the participants to establish the extent of correspondence (Mays and Pope, 2000). However Green and Thorogood (2004) suggest that it would be too positivist to assume that two different persons (researcher and participant) coinciding on their accounts enhance credibility of a study more than the account of one person (researcher) (Green and Thorogood, 2004). In this study participant validation was not used for several reasons. First, the researcher understands that the interpretation of the data is his interpretation and that the interpretation by the participants could be different. Those nurses were rapidly going through different phases in which their views of the present reality might not have prevailed in subsequent encounters due to contextual changes such as reunion with their family, registration with the NMC or perceived threats from changes in

migration regulations. In this situation having asked them to validate data obtained in earlier encounters may have caused distortions of the reality and given an incorrect perception of validity checking. As mentioned before the longitudinal element of this research allowed a relatively prolonged engagement with participants which is suggested as a way of adding truth value to the research (Lincoln and Guba, 1985). This enabled increased reliance and bond between the researcher and the participants. Main themes emerging from one interview were often checked in subsequent interviews with the same participant, either to explore them more in depth or just to confirm that the interpretation of the researcher converged with the views of the participant.

The researcher's supervisors assessed fragments of interview transcripts and interpretations. They also monitored the process of analysis providing regular feed back, refining and sometimes suggesting new directions in the process (Erlandson et al., 1993). During those sessions they often challenged and questioned issues about the process or the content of the analysis which is defined as "peer debriefing" (Lincoln and Guba, 1985). Another form of peer debriefing was achieved when the researcher presented preliminary results in scientific meetings (four during the period covered by the research). The feed-back obtained from scholars and professionals working in nurse migration is believed to have increased the validity of the study (Lincoln and Guba, 1985).

In order to ensure that a good interview technique was being used, the researcher invited an experienced ethnographer to attend one of the interviews. The feedback confirmed that technically the interviews were being undertaken according to good standards.

Reliability refers to the extent to which other researchers using similar methods or the same researcher in a different occasion would find consistent results (Yin, 2003). The use of interview protocols for each group helped the researcher to ensure that all participants covered the same issues throughout. Interview protocols were piloted with an overseas (Indian) health professional who suggested some changes, which were introduced before starting the data collection (Silverman, 1993). During the initial stages of the analysis, data were shared with other researchers for discussion of emerging themes. The use of a digital recording device increased reliability by reproducing high quality audio records, avoiding mistakes due to noise or

misunderstandings while taking notes. The fact that the researcher, listening and reading at the same time, reviewed all transcriptions ensured that they were an accurate reflection of the participant's accounts. The inclusion of direct quotes in the chapters where results are presented, allows the reader to find the source of the interpretation that the researcher made of the raw data contributing also to enhance reliability.

Reflexivity refers to the sensitivity about the extent to which the research process and the researcher's assumptions and experiences have shaped the data collected and their interpretation (Mays and Pope, 2000). Being sensitive does not imply that the researcher needs to exclude him from the process. In this case the researcher has more than 13 years experience working in developing settings. Thus he has experienced the adaptation to new cultures and contexts as part of his professional activity. His experience and professional focus on developing countries could have led him to play an advocate's role for the nurses. During this research he was based in the UK and had shared similar experiences to those expressed by the participants when adapting to the British context.

Some of the issues that emerged and acquired importance in this research could have been influenced by the gender bias introduced by the sampling procedure. Issues such as discrimination or bullying may have applied in a stronger fashion when referred to by female nurses, as they are normally more vulnerable to them. However being an independent researcher not attached to the NHS, may have given the nurses the opportunity of speak out on issues that they might not have disclosed in front of an NHS staff member.

As suggested by Kvale (1996), being knowledgeable in the topics investigated is one of the senses that researchers should have (Kvale, 1996). The fact that the researcher is a nurse helped participants to speak more openly from a technical perspective and is likely that this facilitated a stronger bond between researcher and participants. However, how the researcher's own nursing education, how he defines and conceptualises nursing and his professional experiences may have also affected the understanding of participant's views in this regard. By being aware of this and keeping the right balance between the "etic" and "emic" perspectives, it is expected that the accounts from nurses

were analysed from a neutral position or at least that the reader is able to trace which are the influences that might have guided the findings of this research.

Green and Thorogood (2004) suggest that comparison is what drives qualitative analysis. In this study comparison between cases has been the essence of the analysis and has allowed the researcher to hypothesise and theorise about the experiences of overseas nurses coming to work in the UK. Emerging theory was contrasted against the whole data set, contributing to the rigour of the study. Finally, the comparison of results with empirical findings from other researchers working in the same subject has contributed to validate their theories and to provide consistency to the research findings.

Chapter summary

This chapter has presented the research process starting by introducing the research purpose, objectives and questions. It is an inductive exploratory study based on an interpretive approach that uses qualitative methodologies to illuminate the phenomenon of nurse migration. It is designed as a case study based on a longitudinal follow up of a group of nurses from India complemented with the cross-sectional study of two groups of nurses from the Philippines. Interviews with nurse managers, mentors and recruitment managers were also undertaken. The study was undertaken in a NHS acute Trust in London. Data were generated by face-to-face semi-structured interviews. Documentary review helped to put the study in context. Data obtained through interviews were transcribed and analysed using a framework approach. Ethical issues and mechanisms of quality control and rigour were carefully considered and taken into account. The potential limitations of the study such as the relative generalisability of the findings, the control of the Trust over the recruitment of participants and the gender of the researcher have been presented under each relevant section. Strengths such as the richness of data obtained and the interest that the Trust had in the study outweighed the limitations, and contributed to knowledge about overseas nurses' perceptions and experience in the UK.

Chapter 3: Decision to Emigrate and Recruitment

Introduction

This chapter presents data derived from interviews with all groups of nurses but mainly focuses on the group of Indian nurses for whom the capacity to recall the reasons to emigrate was easier than for other groups that had been already in the UK for a longer period. Pull and push factors influencing the decision making process are presented first. The role played by family and friends is then introduced followed by the process of recruitment and the experiences of these nurses while being recruited.

The decision to emigrate

The decision to emigrate is complex and is influenced by and affects multiple spheres of a person's life. In order to understand why nurses emigrated, this section explores the individual reasons given by the nurses to leave their countries of origin as well as those attracting them to the UK. The social perspectives are illustrated by the influence that family, friends and other social networks contribute to the decision to emigrate. Then the cultural perspective is more focused on the movement of nurses that were working before in Saudi Arabia that represents a good example of how cultural issues affect migration but there were also cultural aspects in their country of origin that contributed to their decision to emigrate.

Individual perspective: push, pull and regulatory factors

When exploring the factors that moved these nurses to take the decision to emigrate, we need to differentiate between first and subsequent migratory movements. Half of the nurses in this study were already living and working outside their home country when they decided to migrate to the UK. If we concentrate on the first movement to, for example, the Gulf States either from the Philippines or India, the main push factor expressed by nurses during interviews was low salaries. A Filipina nurse who had been working in the UK for one year before she was interviewed and who was previously working in Saudi Arabia said:

"...Because our salary is not enough for living, is just enough for the food that we eat, like for eating three times a day and then we cannot go for pleasure like going somewhere else..." ID/F1.1/15.7mUK/YesOSExp

The main pull factor attracting nurses from India or the Philippines to the Middle East was mostly but not exclusively the relatively higher salary. A Filipina nurse who had worked in the UK for one and a half years said:

"I went to Saudi Arabia for my overseas employment, of course [looking] for greener pastures."
ID/F1.2/15.7mUK/YesOSExp

Factors attracting nurses from previous migratory destinations to the UK included better economic conditions in the UK. However in this group of nurses, high salaries were not expressed as emphatically as in previous migratory movements. Professional and personal factors were relatively more attractive the second time as suggested by this Indian nurse:

"When I came from Saudi Arabia, I was mostly expecting something that I can gain, like my skills and knowledge".
ID/Mtr.1/OS

Nurses coming directly to London from India or the Philippines were more likely to express the economic motive more strongly than others, but again it was often not their only motivation. One Indian nurse newly arrived in London with no previous migratory experience said:

"If I go abroad I can earn more and I can do something for my parents before marriage and when I get married I can bring my family over here and children can get good education."
ID/Id5/2dUK/NoOSExp

Nurses in India are obliged to work as interns on a voluntary basis for a period of time after graduation. In India as well as in the Philippines, unemployment among nurses is high and it takes some years for recently graduated nurses to find their first remunerated job. This constitutes a push factor for migration while the availability of employment overseas represents a pull element:

"In India most of the hospitals have many nurses, almost all hospitals got nursing schools, so when they are graduated they do their internship [in the same institution] and if there is [HRR in] excess they will tell us, after completion of internship, to leave the hospital. So we have to try somewhere else for our betterment, for good salary."

ID/Id2/1.5mUK/YesOSExp

Larsen et al (2005) suggest that seeing overseas nurses exclusively as economic migrants is a poor reflection of reality and that other motives need to be looked into (Larsen et al., 2005). Similarly in this study as seen above, the economic factor, despite representing an important influence for decision making in all cases in this study, is not the only factor for migration. Professional and personal factors also play an important role. Within the professional perspective, lack of opportunities for development in the country of origin and in previous migratory destinations often constitutes a main push factor. Nurses frequently know before coming to the UK that opportunities for professional advancement are inherent in the British professional career system, which is perceived as a strong pull factor. An Indian nurse with more than four years experience in the UK who was mentoring one of the newly arrived Indian nurses said:

"I knew before coming that much research was being done here and that there were better opportunities for my career, I mean if you want to study for further degrees or anything, they will allow you to do that. In Saudi Arabia, once you are there you get study days, but you are not entitled for any further study there. Here you are allowed for nursing degrees and courses, like renal courses, like any course you want to do, they allow you, what will improve your skills and knowledge."

ID/Mtr.1/OS

However, it is important to note that nurses may have spoken about professional rather than economic reasons because they perceive the former more morally adequate than the latter.

Lack of clinical resources or poorly equipped facilities in the country of origin was identified as a push factor by some of the nurses like this Indian nurse who reported reusing disposable material in the haemodialysis unit where she used to work back in India:

"...It is different in India you know, there are economic problems, so we used to use the same kidney line [several times]. We use to preserve the kidney line for the same patient of course, that's how the work was..."

ID/Id5/2mUK/NoOSExp

Push factors in countries of origin are often pull factors in the destination country. Having access to more advanced technology and clinical resources was broadly mentioned as an attraction by all groups interviewed:

"Here I hope we can use things nicely [easily], [we will get] better quality materials and equipments like haemodialysis machines, "tubings", pump machines like that I hope here we will get better standards."

ID/Id1/1dUK/NoOSExp

"I thought that London Hospitals were very hi tech, very modern. High buildings, all glass, all windows, hi tech monitors, hi tech, blood pressure monitoring equipment."

ID/F2.1.3/46.5mUK/NoOSExp

However this was more often found among nurses coming from public hospitals in India or the Philippines than among those coming from the private sector in their countries or from working in countries in the Middle East, where often equipment was better and more technologically advanced than in the UK.

Nurses suggested that, by coming to the UK, they expected to improve professionally by practising in an environment with higher standards of care. Two Indian nurses suggested one day after arriving in London:

"...In UK will be better, both professionally and personally, better professional standards."

ID/Id2/1dUK/YesOSExp

"The maintenance of hygiene will be better here."

ID/Id3/1dUK/YesOSExp

From a social and personal perspective, improving standards of living was mentioned by many of the nurses as an important reason for coming to the UK. This Indian nurse with previous migratory experience interviewed just one day after her arrival in London said:

"Life in UK will be better, better than in other countries. Most are considering that being in European countries is better for our future. The standard of living is high. European countries are well developed countries so we will get more chances"

ID/Id2/1dUK/YesOSExp

Another pull factor of a social nature suggested by some of the nurses is the higher social status and increased social respect assigned to migrant nurses back in India and in the Philippines. An Indian nurse said:

"Oh I had to go abroad, and then when I go back everybody will have that feeling that I am coming from abroad and all will respect me."

ID/Id5/2dUK/NoOSExp

Nurses often expected to grow personally through the experience of migration. Living and working in a multicultural environment was important for them. Some of the nurses expressed improved self-esteem since they were in the UK:

"I was not expecting such a variety of cultures around, I thought there would only be white people around... []. At the beginning I was very scared, I couldn't even go to the tube alone, and now I can go anywhere alone by myself, I have travelled alone from here to Manila, Okay, and when I go back home, I feel that I am a very brave person"

ID/F2.1.1/46.5mUK/NoOSExp

Better educational opportunities for children, was frequently suggested mainly by Indian nurses during interviews:

"I wanted my children to have a good education and an orientation to social life. I like the way of teaching in the schools here, the teaching is more practical, not theory based, I like that way, is not just memorising anything."

ID/Id7/7.8mUK/YesOSExp

It was common to hear from many of the nurses, coming from tropical areas like the Philippines or the South of India that the continental climate of Britain was also an attracting factor:

"So, I thought I will feel, I mean I like cold weather actually, so I thought I will just go and see how it is, and whether I can tolerate or not. I used to see in the newspapers and see in the television news that there are snowfalls

everywhere in London. So I thought, I will go and experience the snowfalls also which is not there in Delhi".

ID/Id3/1dUK/YesOSExp

Some of the nurses had more personal reasons to come to the UK:

"Because I want to have a child; in five years of marriage we couldn't have a child, so the doctor advised us to go to a cold country, because our country is too hot. So we applied to come here and fortunately I am now five weeks [pregnant]. Also If you are in UK, you can go on holidays to Paris, Spain or to Germany it is so easy to go!"

ID/F1.3/15.7mUK/YesOSExp

While push and pull factors determine the direction of the migratory flow, regulatory factors modulate the size of the flow (Mejla, 1978b). Regulatory factors refer here to those legal or professional requirements in countries of origin and destination and all the administrative processes and costs that allow the migrant nurse to leave her country of origin, to enter and work in the new country as a nurse. Costs include a non-refundable application fee of £140 (twice the average monthly salary of an Indian or Filipino nurse). The NMC imposed these rates to limit the number of applications to nurses who have definitely decided to emigrate (personal communication with a NMC officer). After processing applications, the NMC often impose conditions such as the need to undertake a supervised practice programme before final registration which is informed through the so called "decision letter". The decision letter is a pre-requisite to proceed with the recruitment. The process often took several months. This Indian nurse explained the difficulties faced during this process:

"Initially I could not get the NMC application package. I wrote many times to get that but I could not get the forms. I had to contact one of my friends here [in UK] and she got the forms and sent them to me. Then I forwarded it and it took nearly a year for me to get the NMC decision letter"

ID/Id3/1dUK/YesOSExp

Some recruitment agencies offer support during the process of application, but often nurses had already advanced these processes before being approached by the agency. Nurses that were working in a previous migratory destination started the process before finishing their contracts:

"I decided to go home [from Saudi] for good, so I applied for NMC. Then in 3 or 4 months I ended my contract and when I went home I already had my NMC decision letter there."
ID/F1.4/15.8mUK/YesOSExp

In order to enter the UK and work as a nurse, the Home Office requires every nurse to have a 'Statement of Entry on the NMC Register' (decision letter), a job offer, and in some cases, a valid work permit. Normally it is the employer, in this case the Trust, with the support of the recruitment agency, which is responsible for getting the work permit for these nurses. Nurses also need to get an appropriate visa from the British Embassy in their country.

The social perspective: migratory networks

The role of social networks in migration has been broadly studied from different perspectives. Migratory networks attract professionals from low income to more industrialised countries (Martineu et al., 2002). Some argue that social networks maintain migratory flows by means of information and facilitating the migratory process (Ravenstein, 1885; Lee, 1966; Ritchey, 1976; Boyd, 1989). This was corroborated in this study where friends, family and colleagues helped nurses to make the decision to emigrate and then helped them to assimilate. Many of the nurses interviewed, regardless of their nationality or previous migratory experience had followed other colleagues and friends.

"...Because I had friends from the Philippines in Saudi Arabia so that encouraged me to go there because at least I had friends willing to give a hand in case of a crisis or something"
ID/F1.6/16mUK/YesOSExp

All the nurses in this study were recruited in groups. These groups, often called "batches" by Filipina nurses, provided an important social network that supported them particularly during the process of adaptation to the new environment.

"I was feeling homesick, I couldn't eat, but I use to go to my friends room just to stay with them for a while..."
ID/F1.1/15.7mUK/YesOSExp

Family members are often influential actors involved in the decision-making process as suggested by many of the nurses. In both Filipino as well as in Indian culture family ties are strong (Trager, 1988; Seymour, 1999). Among the Filipino group in this study, the mother is often mentioned as important, not only in the decision to emigrate but often also in the decision to undertake nursing studies:

"...Most Filipino nurses were sent by their parents to take up nursing because it is a lot of money when you get out of the country and work abroad, like in the States which was very popular before. But for myself I did not take up nursing because I wanted, but because my mother wanted it, for me, but later in the years I liked it. Yeah"

ID/F2.1.2/46.5mUK/NoOSExp

The cultural perspective: history, religion and gender

Out of 22 nurses interviewed 11 had worked in Middle East countries, nine of them in Saudi Arabia. Important factors contributing to the decision to emigrate from these countries, particularly among those having chosen Saudi Arabia as their first migratory destination were of a cultural nature such as religion or gender issues. The practice of any other religion rather than Islam is prohibited in Saudi Arabia. Nurses coming from Saudi Arabia mentioned that one of the reasons for them to move to the UK was the fact that they were not able to practise their religion freely what, being a group with strong catholic convictions, was perceived as a strong discouraging factor.

"Religion wise, we were very restricted. For worship we couldn't let the sound to go outside, we had one room separated for that, so we sealed the room, and keep that on Sundays for all of our friends to come together and have the pray."

ID/Id7/1.5mUK/YesOSExp

Many also expressed their disappointment with the fact that being women living within an Islamic society was difficult mainly due to what was perceived as imposed restrictions on their choice of dressing. Even foreign women are obliged to wear "hijab" (veil) when they go out of their premises.

"...Because as a woman you can't go out without the head covered."

ID/F1.3/15.7mUK/YesOSExp

Another element perceived as difficult was the restrictions of movement that they had for being women. The employers in Saudi Arabia retained their passports upon arrival in the country. Foreigners have to declare their religion to the immigration authorities. Muslims are given a green visa while “infidels” are provided with a purple visa for easy identification. Nurses in this study were only allowed to leave the premises of the hospital where they lived, in a special bus and only after having got permission from the responsible authority.

“The advantage here compared to Saudi is that in Saudi you cannot travel.”
ID/F1.6/16mUK/YesOSExp

In Kerala the custom for marriage is that families from the bride have to pay a compensation (“dowry”) to the family of the groom before the wedding (Percot, 2005). Sometimes nurses are able to cover the “dowry” with their earnings abroad and pay back the investment that their families made when they paid for her nursing studies as suggested by this Indian nurse:

“Because my marriage is fixed and there is no need for my father to give any money for the marriage, everything I’m giving so I feel proud of it”
ID/d5/2dUK/NoOSExp

Other cultural aspect that contributes to the decision to emigrate among nurses from Kerala is proposed early marriages from which they can escape by emigrating. Social structure in Kerala revolves around the family. George (2005) mentioned in her study about migrant nurses from Kerala, that elder members in the family have to be involved in decisions made by younger members which is sometimes perceived as too restrictive by highly educated nurses who, having the opportunity to have a more independent life, opt for emigration (George, 2005). There is broad evidence of the influence that colonial ties exert on migration.

The choice of destination

The selection of the destination is often influenced by history and tradition of migration. In the Philippines, due to historical colonial links, the traditional migratory destination for nurses is the U.S. (Choy, 2003). However sometimes nurses prefer other countries for different reasons. Similarly for Indian nurses, the UK is a natural migratory destination due to the historical ties between both countries. However Indian nurses

migrate also to the U.S. Some of the nurses, in particular Filipinas, mentioned contractual conditions, other than salary, as an important attracting factor to the UK as compared with the U.S. as this Filipina nurse suggested:

"...Lot of my friends are there [U.S.] already, but I have heard from them, that they are only allowed to have two weeks holiday and I think that it is more important for me to have longer holidays... Here is 37 days it's more than a month, yeah. During holidays I normally go home to visit my family. Sometimes I just get 4 to 5 weeks because it's a long flight, 17 hours. I like to have a few weeks left just in case I am really tired and need a rest [during the rest of the year]."

ID/F2.1.2/46.5mUK/NoOSExp

Once the decision to emigrate is made, nurses start looking for job opportunities, often in a specific country, but sometimes on the basis of available opportunities. This Filipina nurse said:

"Well during that time when I went home [from Saudi Arabia] it was the UK who was having this recruitment so I just tried my luck..."

ID/F1.1/15.7mUK/YesOSExp

The legal requirements for professional registration and immigration at the destination country and the complexity and length of these processes are also cited as influencing the choice of destination:

"No. 1 is USA but it is quite tough with applicants, you have to do so many tests, so many requirements, so many years of experience, before you qualify to the U.S., and even when you are already there you have to take examinations. I think UK is quite good, they only require you to do adaptation [programme], as long as you pass the adaptation, that's it..."

ID/F2.2.1/55.4mUK/NoOSExp

Time for deployment is another factor influencing the choice of destination. As suggested by Khadria (2007) the waiting period for Indian nurses to migrate to the UK is as short as 6 months while the time for deployment to the U.S. is up to 2 years (Khadria, 2007).

The family of the nurse, once more, influences the destination country decision as suggested by this Indian nurse:

"My mother had planned for us. She [sister] had to complete her post basic [training], and I had to complete my BSc Nursing and then we both could go out [emigrate] together to the UK. That was her dream."
ID/Id4/2dUK/NoOSExp

The recruitment process

The situation of the nursing labour market and the most common policies and practices in international recruitment in the UK, have been documented in Chapter one. In this section the process of recruitment undertaken by the Trust under study is described. Two senior nursing managers who were involved in the recruitment of some of the participants were interviewed about their experiences. Their views are first presented together with the perceptions and experiences of nurses during their own recruitment.

Recruitment here is considered as the process of going from the first contact that nurses had with the local recruitment agency until their arrival in the UK. Despite sporadic recruitment undertaken in New Zealand and Australia before, the Trust under study has been actively recruiting nurses internationally in a systematic way since the year 2000. They recruited an average of 60 nurses per year, mainly from India and the Philippines. All nurses participating in this study were actively recruited by the Trust in their country of origin.

In every case the Trust commissioned a British recruitment agency, which was at the same time working with local agencies to support the process. The Trust provided the British agency with the profile and the number of nurses required. Local agencies were in charge of advertising the positions and screening nurses according to the established criteria. The Trust, supported logistically by the recruitment agency, was then sending a recruitment team constituted by senior nurse managers and specialists from the HR Department to complete the selection process.

Most nurses got information about recruitment opportunities in local (Indian and Filipino) newspapers, which are also available in countries of the Middle East:

"...there were so many ads in Indian newspapers, so I collected a few and then I compared whatever things they were requiring ..."
ID/Id2/1dUK/YesOSExp

Some used the services of local agencies to move initially to the Middle East and it was through these same agencies that they received information about UK opportunities. Once in contact with a recruitment agency, most nurses were requested to send a CV for a first screening. As part of the screening, some of the nurses were also interviewed by the local recruitment agency by telephone. Others reported having had to sit an examination.

"Right, basically I read in The Bulletin newspaper in Manila, an ad [advertisement] informing that they were recruiting nurses here in UK. So, I went to that recruitment agency in Manila the following day. I just applied straight away, and they gave me an examination, a written examination."

ID/Mtr.4/OS

Nurses that were working abroad went back to their countries of origin to be interviewed. Some of them reported having done part of the paperwork while still working at their migratory destination.

The agency offered support to the nurses on filling and sending the application forms to the NMC and to the Trust:

"...the agencies actually were helping them with the applications, the wording was incredibly similar."

ID/Recl1/B

The Trust recruitment team sometimes perceived the screening process undertaken by the local recruitment agency as below expected standards:

"...they were all supposedly screened out beforehand. The reality was that actually when we went there to interview them, you knew that you were talking to a very inexperienced junior person, and, they hadn't been screened fantastically well. So we were interviewing many people that we didn't need, that we shouldn't be interviewing."

ID/Recl1/B

Once screened and pre-selected and before their interview with recruiters from the Trust coming from London, nurses were briefed by the recruitment agency about the UK, the Trust and what they could expect from the job offered. Often information provided in those sessions was not accurate as suggested by one of the recruitment managers:

"I don't think they were very well prepared for what to expect. Their understanding of where they would be coming to work was very poor."

ID/Recl1/B

The same recruiter mentioned how the recruitment agency was briefing the nurses about the UK:

"...we suddenly realised why their perception was what it was, that's what they had been told and actually the agency had this glossy pictures of Buckingham Palace and Tower Bridge and the Houses of Parliament and that's what they were given to look at during the briefing session and they didn't have one picture from the hospital [in London]."

ID/Recl1/B

They were then called for an interview with the recruitment team from the Trust. Agencies sometimes arranged those interviews to take place in several main cities in the country to facilitate access for nurses whom otherwise might not have been able to attend the interviews due to long distances and the high cost of transport:

"They called me at home saying that they were coming for an interview and asked me in which place would I like to go for an interview as they were coming to different parts of India."

ID/Id3/1dUK/YesOSExp

During one of the first recruitment missions in 2000, recruiters from the Trust were interviewing an average of 90 nurses per day during six days and the average number recruited was around 70. Thus, 7 or 8 nurses were interviewed for each vacancy.

The content of the recruitment interview depended on the professional level of nurses that the Trust was looking for. At the time of the recruitment of the group coming from India, the Trust was experiencing difficulties in finding senior staff nurses (E grade) and one of the criteria established for their recruitment was to have experience in ward management. Accordingly, the content of the interview was largely technical and managerial:

"They were asking me about everything, many technical things but also how to manage the department".

ID/Id1/1dUK/NoOSExp

Both recruitment managers interviewed for this study acknowledged the fact that during the first recruitment missions in 2000 they were not well prepared about the country and its people and about professional issues specific to either India or to the Philippines:

"So we were naive in that sense that we really were not prepared for the extremes out there [referring to poverty] and naive in thinking that we could interview in exactly the same way we do interview in this country. We were completely unprepared about that."

ID/Rec1/B

Given the low level of preparation of the recruiters about the situation in the country, their shock at the experience of poverty, together with the stories that some of the nurses told them about their difficulties in living on a Filipino salary, the recruiters may have felt they needed to help applicants go through the interview:

"They didn't necessarily understand what I was asking them so I had to repeat what I was asking them, but then I had to coach them in giving me the answer that I wanted as well or coach them into doing that by prompting them."

ID/Rec1/B

After the interview some of the nurses reported having had a second telephone interview with managers from the wards in which they were going to be assigned, who could not travel themselves to the countries for recruitment.

In this study all nurses were recruited in cohorts. Cohorts are thought to increase efficiency for the Trust and to reduce the cost of migration to nurses (Smith et al., 2006). One of the recruitment managers commented that in one of the trips they recruited 75 nurses that came to the UK and six months later they went again and recruited another 75. All these nurses came to the UK in cohorts of 25 around six months after their interview.

Once nurses were selected they waited between three and six months for their deployment. Nurses that were interviewed in May 2000 arrived in London in August, October and November the same year. Deployment of recruited nurses into the UK was fast as reported by the nurses involved in this study. However some reported different

experiences with other employers. Long periods of inactivity while waiting for deployment have serious economic implications for nurses.

"... When Irish people tried to recruit us from Saudi Arabia I was supposed to be recruited for Ireland. Then we passed all the interviews and exams in Saudi. Then they told us to resign by October 2002. I resigned from my hospital and I went home to the Philippines. Then I was expecting them to call me. Unfortunately they kept postponing our date of deployment. Everything was finished: our physical exam, our papers ready to go, everything in the agency was already ready. Only our deployment was not clarified. So by the time this Trust published a classified ad in the newspaper I went and apply in Manila. Then luckily I passed all the exams, initial interview, final interview and the exam so, luckily I came here in November 2003."

ID/F1.2/15.7mUK/YesOSExp

The experiences of arrival in the UK were diverse. Evidence from other studies suggests that many nurses recruited by agencies alone without the participation of the employer, or directly by home care institutions have negative experiences while many NHS recruited nurses perceive their arrival and reception as positive and supportive (Allan and Larsen, 2003; Smith et al., 2006). The experience of being recruited and brought to the UK in cohorts seems to be easier as suggested by the mentor of one of the Indian nurses who was from India herself who reported having come to the UK on her own initiative.

"...When I came here, I... actually it will make me cry to talk about it... it was very bad experience. My accommodation which I had booked from Saudi Arabia, it was gone, that lady had given it to somebody else and when I came to London airport, I called her, she said sorry, you didn't call me back to confirm that accommodation, so I did give that to somebody else, so it was very bad experience, and I was lucky that when I went to Liverpool, it was Friday, Friday afternoon, and fortunately that school of nursing wasn't closed. They arranged accommodation for me. It was my first experience, away from my home and when they tell you that you haven't got any accommodation to stay and I don't know anyone here. It was a horrible experience..."

ID/Mtr.1/OS

The Trust has learned through the years about what nurses perceive as essential for their initial adaptation. Now it is common for NHS employers to provide relatively affordable housing during the first months, induction sessions with information about

British culture, use of services like transport or availability of religious services in the local area and even telephone communication with their families (Buchan, 2003).

The group of Indian nurses received a thorough briefing during a session also attended by the researcher. Despite the contents of the briefing being adequate the fact that this important information was provided on the same day of their arrival might not have been a good choice. Nurses were tired and did not yet know many of the issues presented.

Few nurses in this study reported any negative experience upon arrival in London, except for flight delays and long transits. Most found somebody to meet them at the airport that went with them to their accommodation. The Trust offered Hospital accommodation free for the first month and at subsidised prices for the rest of the period of adaptation. To the last group recruited in 2005 they also provide food tokens and a bus card for the first month.

"Nothing was difficult. It was okay. Bridget [from recruitment agency] was there at the airport. She arranged a bus and sent us here. Then Peter [from the Trust] came and assisted us. Then we got our accommodation and immediately we called up home. We got also those food voucher is very good, 'that's very helpful.'"

ID/1d5/2dUK/NoOSExp

Chapter summary

This chapter has presented the experiences of nurses from when they decided to emigrate to the UK up to their arrival in London. The different factors, which were mainly of an economic, professional and personal nature, influencing their decision and their experiences during the recruitment process illustrate the first stages of their migratory experience. Regulations in country of origin and destination influence the decision making process, particularly the choice of destination. These first experiences were essential in the development of expectations about their future and also influenced their attitudes towards the employer. Having arrived in London, nurses started to go through a complex process of adaptation that might influence their experiences and future plans which is the content of the next chapter.

Chapter 4: Professional and Cultural Adaptation

Introduction

Evidence suggests that there is a strong relationship between the early experiences of working in an organization and the employee's career (Kotter, 1973). This chapter presents findings about the process of adaptation that nurses experienced concentrating on their professional and working environment. It introduces the Overseas Nurses' Programme (see pages 38-40), and the experiences and perceptions of nurses about the programme. Then it presents the difficulties that these nurses find in adapting to their new environment, and the coping mechanisms they use to face up to problems.

The adaptation process

In order to identify phases in the process of adaptation this study has used Pilette's model of adaptation (see Chapter 1), as the framework against which the experiences of nurses were compared and contrasted. Nurses who have qualified abroad have to undertake the Overseas Nurses' Programme (ONP) in order to obtain their license to practice in the UK. The programme aims to help them transfer and adapt their professional skills to the British system ensuring at the same time an appropriate level of safety and quality of care. It constitutes an important element of the adaptation process.

The arrival of internationally recruited nurses in the UK is the start of a whole process of adjustment to the new environment. However the experiences pre-departure constitute an important part of the experience with important implications for the whole process of adaptation. The group of Indian nurses reported their excitement during the pre-departure process. They were busy having interviews, gathering information, going through all the administrative processes and getting prepared for their departure. Many expressed the satisfaction they felt when they were offered a post in the Trust. Using Pilette's framework (see pages 37-38) this would coincide with the "*overseas meeting*" element of the "*acquaintance*" phase. Attitudes identified during the first days after arrival suggested expectation, optimism and uncertainty. Nurses were starting their orientation sessions and experiencing their first contacts with the Trust and the

professional staff at the hospitals where they were assigned. Those coming from a previous migratory destination expressed their disillusionment with the accommodation provided, in particular when they were told that they had to pay for it. In Saudi Arabia, accommodation of a relatively higher standard was provided free of charge. There were also multiple reports of loneliness, homesickness and isolation comparable with Pilette's "post orientation" period within the "acquaintance" phase. This account from one of the Indian nurses captures well the experience of the group at this stage of their experience:

"We have to take everything for good and be optimistic. NHS is very good it is providing good salary, providing good immediate adaptation and here we will be posted in good hospitals and we can learn and earn more.[...] I don't know, I just came over here but I feel the people are good over here."
ID/Id5/2dUK/NoOSExp

During the second interview one and a half months after the first, most Indian nurses expressed feelings of satisfaction and progress in their adjustment to their new working environment and colleagues. However frustration generated in particular by the limitations in the scope of their practice due to the restrictions imposed by the supervised practice period was also reported. Nevertheless the experiences of nurses at this stage were still positive in general and it could still be compared with Pilette's first phase of "acquaintance":

"This is great. The last time I was so afraid of everything, you know? Do you remember? I was afraid of the culture, the people, discrimination, everything, I was so afraid, but I have never found anything like that, it's a pleasant environment, we are getting adapted, yeah."
ID/Id5/2mUK/NoOSExp

However, eight months after arrival, nurses reported a sense of crisis. They were immersed in the new culture and working environment and were conscious of the major differences in respect to their previous experiences either in their previous migratory destinations or in their country of origin. They had started to realise that their expectations were not being met, and that their initial plans needed to be adjusted to the reality they found. This phase can be compared with Pilette's phase of "indignation", but it takes place before the end of the orientation/probation period:

"...we heard from London that is one step down from heaven, and then you come over here and you cannot see anything, I don't find that everything is so good because I don't know, I am that person that is more family atmosphere, more of our place, and I always think about our place, villages, for me... I don't find anything out of this. For me is a little bit tough to come over here, big city, rush everywhere, I was feeling so lonely and we are finding difficulties with the housing. I am planning to stay here for four years, and then I'm planning to go back to India. By then I may have children and I don't want them to live over here because I've seen the children which are growing over here, what can I say, is not like the ones growing up in India, I'd like my children to be very nice, obedient, God fearing"

ID/Id5/7.8mUK/NoOSExp

The attitude of one of the nurses who completed her ONP and registered with the NMC in three months continued to describe this period as a time of shock and dissonance including professional frustration due to perceived unfairness in how she was treated by managers:

"The way they behave, the way they treat us. You can't treat anybody like that! If I say you -oh you don't know anything. Don't say that, you can't say that by their colour. If I am so bad, how can I've been in a high position for so long time in another place?"

ID/Id7/7.8mUK/YesOSExp

It is difficult to compare the experience of Indian and Filipina nurses due to the different motivations and objectives of their migratory experience, which essentially are, for Filipina nurses to help their families back home and for the Indian nurses to bring their families and stay in the UK. Pilette's framework covers only the first year of adjustment but it will be used here to identify different attitudes presented by Filipina nurses after one year in the UK and those after four years. Most nurses interviewed after one year in the UK reported professional frustration in some areas. However most of them acknowledged the fact that they were in the process of adjusting to these new professional experiences. Some of them reported starting to be aware of the "different" treatment they were getting from managers and colleagues, which indicates that they were experiencing discrimination but none expressed it that explicitly. The fact that all nurses in this group worked in the same ward and under the same management needs to be noted as this may have influenced their experience, and certainly a sample of nurses in different wards might have provided a more varied range of professional attitudes and perceptions.

"It was not really difficult, it is a matter of adjusting and practising it daily, because in the Philippines we don't use to have somebody checking with you all the time while giving the medications, here you always have to be with somebody. [...] I am already adjusted to my job so far. The people I work with are okay with me, except for some of them but so far they are starting to be nice to me, not like the first time when you arrive."

ID/F1.4/15.8mUK/YesOSExp

With regard to their personal life most nurses reported having problems but recognised they were adapting to the new situation. They mentioned getting accustomed to some aspects of life in London like the high cost of living, the multicultural environment or the complex transport network, but still struggled with other issues such as the different moral values, the weather or the perceived social disengagement of British society. Most recognised having better living standards in the UK than in Saudi Arabia but still missed the Philippines. These experiences are closer to Pilette's third phase of "*conflict resolution*" than to the fourth phase of "*integration*", except that in her study "*conflict resolution*" starts immediately after the completion of the ONP and the latter nine months from after arrival.

Although some of the nurses from the four year group said they were not planning to stay much longer, they presented a more positive attitude towards the new culture and working environment. Half of this group had not succeeded in progressing up the professional ladder beyond junior positions while others already held senior staff-nurse grades at the time of interview. There is a substantial difference in attitudes presented between those two groups. Those who remained in junior positions after four years in the UK expressed general frustration, low self-esteem and poor adaptation to British life:

"...Things are getting worse, you see the cost of life, I mean the housing, the transport, I mean the everyday consumption plus the tax; it is too much! That's why I told my colleagues down there, I told my friends do not come here anymore, you better stay there. Another thing that I don't like here is the weather, its really bad weather I cannot get any exercise that's why I am so big. My room is very small; I don't have space. You just want to drink and sleep and eat, and then watch the "telly"; I hate that because I always used to go out."

ID/F2.1.4/46mUK/YesOSExp

The following quote from a Filipina nurse is representative of the more positive perceptions of these nurses in the group who managed to get relatively more senior positions:

"I am enjoying my job here, everyone is so wonderful, and everyone is so supportive. The other colleagues are very good! We are very close here, it seems we are sisters, after the shift we go out and eat together, I think, because most of us we are the same age, three of us from Philippines and the rest from other countries."

ID/F2.2.2/51.8mUK/NoOSExp

Within the two sub-groups of Filipina nurses who had arrived in the UK more than four years prior to the interview, it was found that despite having been in the UK for a similar period of time, some of them were in a more evolved phase of adaptation than the others. Those who had progressed in their professional career were in a phase comparable to Pilette's "integration" phase. The others however who still held junior positions after more than four years, appears to be suspended in the third phase of "conflict resolution", being increasingly aware of the gap between their aspirations and their limited ability to realise them.

The overseas' nurses programme (ONP)

Most nurses trained outside the European Union are required by the NMC to undertake an adaptation programme known as the Overseas Nurses Programme (ONP) before allowing them to practise unsupervised in the UK as registered nurses (see ONP curriculum in annex 8).

The group of Indian nurses in this study received a briefing session on the same day of arrival in which they were presented with day-to-day facts of life in London such as security, local shops or transport. They were then provided with a one-week in-class induction programme about NHS policies and regulations. This induction commenced just four days after arrival. Some of the nurses found that receiving all that information upon arrival was overwhelming:

"...The induction was bombarding, more and more things, we couldn't concentrate..."

ID/Id2/1.5mUK/YesOSExp

As part of the theoretical component of the ONP, the twenty study days were perceived very positively by most of the nurses.

"Of course study classes were very good and we enjoyed very much study days of course..."
ID/Id1/7.5mUK/NoOSExp

Nurses in general appreciated the ONP however most of them got frustrated with the limitations in the scope of practice during the programme:

"Actually about the adaptation there is a problem. When you are already doing the same work back home and suddenly you are blocked, I mean you are not supposed to give medicines and you are not supposed to do that and you are not supposed to do this because you are still under supervision you feel yourself as a useless person..."
ID/Id3/1.6mUK/YesOSExp

Some of the nurses interviewed perceived the ONP as a mere pre-requisite to registration and hence something that they had to go through if they wanted to succeed in their goals:

"It is not a very good thing that you are, just like student, I mean as if you were new to your nursing life, but after I realized that I had to go through that, and that was the only way to be able to succeed... [In getting registered with the NMC]."
ID/Mtr.1/OS

The group of Filipina nurses, who arrived in London one and a half years before, were assigned an overall mentor who was looking after them. She was not only looking after their professional adaptation but also dealt with other issues such as making sure that they had appropriate clothing, that they knew where the basic facilities such as shops, worship venues, etc. were. It was mentioned by all nurses in this group that the figure of this overall mentor was key for their adaptation.

"Because our director was guiding us, we were in fact calling her mummy. She is nice, she is really nice and is guiding us well, she is telling us to be careful like that, she oriented us on what to do and what not to do. Even personal wise and also clinical wise she uses to advice us because she knew that we are alone here."
ID/F1.2/16mUK/YesOSExp

Nurses perceived some aspects of British nursing as strongly positive and attractive. They suggested that British nurses exercise their profession in a more autonomous way than they normally do back in their home countries. There are some tasks that are delegated from the medical profession but most are nursing initiatives independently performed mostly based on nursing evidence. In India and the Philippines nurses in this study suggested that nursing in their countries is mostly subordinated to the medical profession.

"Here it is better, because there it is doctor led, even if you are a head nurse, you are only following orders, you are not the one who decides. You can suggest, but not decide and here it is not like that, you are the one leading your patient's care, so you feel more satisfied in your work area, so I think it is better that way".

ID/d7/1.5mUK/YesOSExp

Some of the nurses found the ONP a safe way to work during the first months in which they were not overwhelmed by being fully accountable for the responsibilities of a registered nurse. This gave time for them to observe and learn about the British system:

"...Because everybody see us as students they have got more consideration for us while if they see us as a staff nurses they won't be having that much consideration; so the adaptation programme itself is very good"

ID/d5/2mUK/NoOSExp

Mentorship

Support from mentors in this study was variable. Many nurses reported having had a positive experience and having benefited from the mentorship scheme for their professional integration. Some explicitly spoke about a good relationship with the mentor having been central to the process.

"...He is a very good man, he helps me a lot, and even he takes care of me very well. When he is not working and I am there, he will tell the previous day to someone to look after me and otherwise, also he tells me each and everything. He sometimes tells me - I know you know it but still I am supposed to explain it to you."

ID/d3/1.6mUK/YesOSExp

However, not all the nurses perceived mentorship as a positive experience. Mentors were sometimes not working the same shift as the nurses, other times they left the organization and were not replaced:

"...They have selected a mentor but it happened that they are also busy doing their job... My mentor went in July, she went to another unit and then she left the hospital, that was no problem to me, it didn't make any problem to me because the patient side I don't feel any problem [IV- Did you get another mentor in July?] No, not until August..."

ID/Id1/7.5mUK/NoOSExp

The role played by ward managers in preparing the mentorship component of the ONP before the arrival of the IRN was found to make an important difference. Two of the nurses who had positive experiences during their mentorship were supervised by two of the ward managers who explicitly reported having prepared the mentorship beforehand with the mentor assigned. This preparation consisted of planning shifts together, for example to accommodate working nights to allow maximum contact time, or having preliminary briefing sessions with mentors about the nurse assigned to them as mentee, as this manager suggested:

"Well, the interesting thing this time is that I actually received from Peter [Trust recruitment officer], all the information, their application forms and everything, and pictures of them, so I knew who they were, what they looked like and what their backgrounds were, so based on that, we can look at their mentors, and I sat their mentors down and gave them their application forms. So they could see what they looked like, they knew what experience they were coming with, because the last thing you want to do is teach things that they already know and to bring down their confidence level."

ID/Mgr.4/Br

However some mentors appeared not to be aware that these IRNs were experienced and skilled professionals. Their attitude was more like mentoring a nursing student or a just graduated nurse. An Indian nurse with 20 years experience in intensive care said:

"My mentor was asking me -how do you take pulse? My son can tell you that how do you take pulse! (angry) They just go for very basic things."

ID/Id7/7.8mUK/YesOSExp

Mentors in this study sometimes did not feel prepared to mentor internationally recruited nurses:

"Well I have to say that I don't think I have received anything from the Trust for me to be a mentor. I did do the course, well okay, I did do the mentorship course, but not for foreign nurses, that wasn't really, it was a few years ago, and it was for people on a development programme, from D to E Grades, an ENB100s and I think, certainly at that point, I don't remember being given any tips on foreign nurses, which are going to be different."

ID/Mtr.3/Br

Assessment of professional proficiency

One of the objectives of the ONP and more specifically of the mentorship is to assess the professional proficiency of overseas nurses. However some of the very experienced nurses reported that the ONP was not adequate for this purpose. Due to limitations in the scope of practice imposed by the professional grading system, nurses are not able to perform certain tasks during the adaptation period. This makes it difficult for the person assessing to evaluate certain skills. One particular experience of a nurse with long experience in critical care is illustrated here. The interview took place eight months after her arrival in London. She perceived that the process of assessment was sometimes unfair, as it was not based on objective criteria. This nurse expressed her frustration about this and also about the fact that during recruitment in India she understood that the job offered was in a senior position. She had problems being signed off from the ONP at the level that she was promised in India:

"...They didn't try us, they didn't give us enough chance to prove that we are OK for that and they just told us that we were not fit for that grade or we were not prepared for that so they were not happy to give us the E grade. There is no exam, they just say that, they just say you are not fit for that, you know is a personal assessment, there is no especial exam for that or anything."

ID/Id7/7.8mUK/YesOSExp

Some of the nurses assigned to highly specialised services such as critical care during the supervised practice were not counted in the unit's establishment. They were just supernumerary to the normal number of nurses in the ward with a very limited scope of practice. They suggested that their supernumerary status did not allow the mentor and supervisors to assess their skills.

One of the managers in a different ward than the previous Indian nurse supported this hypothesis about the inadequacy of overseas nurses' programme as an assessment tool for specialised wards:

"The adaptation course is to assess them in relation to their professionalism for qualifications as a registered nurse, but it doesn't necessarily assess them as nurses within a speciality..."

ID/Mgr.3/Br

Barriers to adaptation

The main barriers that nurses found in the process of adaptation to their new environment were communication/language and professional disparities such as different professional identity, different organization of the work and different relational patterns with peers, patients and other workers. Disparities based on the different cultural environment were also found sometimes as an obstacle for adaptation.

Communication/language

Communication with colleagues, managers, mentors and patients was mostly reported as a perceived problem in the work place rather than in nurses' personal life out of the hospital environment.

Despite having obtained the necessary scores in English tests as a requirement for registration with the NMC, nurses found difficulties in understanding different accents and sometimes the hospital jargon:

"Initially with the communication, you find it difficult because of the accent, its difficult, and then same things, like the words they're using like they have these kind of words that you don't use like the lift, we don't use lift at all, we use elevator. And then using the bottle, we don't use bottle, its urinal at home, they have so many medical terms and terminologies, which are like, quite not familiar to us..."

ID/F2.2.3/52.5mUK/NoOSExp

Many of the nurses mentioned answering the telephone in the work place as a major challenge. This could be explained by the fact that when using a language in which one

is not fluent, non-verbal communication helps the process of communication what is not possible when using the telephone.

Filipino nurses often live together, sharing housing, habits and routines. They also tend to get together during breaks in working hours. When they are together they often use their own language, which is seen by some managers as negative for their adaptation.

"...Now it is explained by the Trust that they are expected to speak in English, when they are at work but in the coffee room they will slip into their own language."
ID/Mgr.3/Br

Communication with patients was also sometimes perceived as difficult because of poor English or different accents, or due to problems caused by lack of understanding of different modes of expression of feelings or emotions. Some nurses expressed their concern about this:

"... Back home is like if people feel they want to cry they will cry, if they feel like [they want] to laugh they will laugh, [but] here they don't express much, they keep it inside I think so I don't know, so it is, I have to think first how will I ask them about their feelings, what are their feelings during the dialysis also they will go through all that pain and many difficulties they go through, so every time I keep watching because by their face only you will notice, some of them won't say, but back home is not like that, they will cry, they will say, they will express themselves."
ID/Id1/7.5mUK/NoOSExp

Professional disparities

Within the professional perspective one theme that emerged strongly during the analysis of the nurses' interviews was the different professional identity between nurses in their country of origin and in the UK. Professional identity is developed during education and practice through socialization of the nurse into the skills, values, norms and culture of the nursing profession (Ohlen and Segesten, 1998; Shuval, 2000). Socialization starts at the nursing school and continues throughout professional life. Hunt and Symonds (1995) argue that the way in which an occupational identity is constructed and reinforced includes work practices and strategies of control, use of language and public representations of this image (Hunt and Symonds, 1995).

Nursing roles

Overseas nurses recently arrived, when asked about differences in the new work environment and their nursing roles, tended to answer that there were not essential differences.

"I think when it comes to the care of the patient it is all the same, I feel, I mean we give importance to the patient care, there is no difference, I mean, I did not feel any difference, as such when you are working, sincerely."
ID/Id3/1.6mUK/YesOSExp

This perception seemed not to change during the process of adaptation to the UK system and all groups agreed that:

"... Nursing is nursing everywhere."
ID/F1.5/15.7mUK/YesOSExp

"... Yeah it's just the same, the same care I rendered to my patients back at home, the same care..."
ID/F2.1.2/46.5mUK/NoOSExp

However most of the overseas nurses interviewed identified that nurses in the UK do things differently than nurses in their countries of origin.

"I think it is different, because here there is no limitation what the nurses can do, everything is for nurses, like the nurse will be expected to liaise with everybody like physiotherapist, social worker, everything, but back home we don't do that."
ID/F2.2.3/52.5mUK/NoOSExp

One of the factors influencing the different nursing roles comes from the limitation of the scope of practice due to the professional career grading system. There are techniques and procedures that require special training and accreditation in the UK. IRNs involved in this study placed a major importance on technical abilities sometimes giving the impression that it constitutes a central element of their professional identity. Some of them reported being able to perform complex technical procedures as an essential element of their professional status and seniority:

"Actually I am so confident that I can work in that, as long you have to maintain the machine, the patient, emergencies and all the things together you'll have to manage, even doing catheterization also when this thing femoral vein catheter I do myself, subclavian also I have done..."

ID/d1/1dUK/NoOSExp

One nurse with long experience of critical care nursing was not able to give IV drugs in the UK, even after having completed her ONP. She had obtained her certification for this specific technique in her previous migratory destination and previously in India but it was not recognised in the UK.

Some techniques and procedures that were applied by nurses in other countries could only be executed by medical staff in the UK as suggested by this Filipina nurse:

"...One of our disappointments when we came here was that while we were doing IV [intravenous] canulation in Saudi Arabia, it is Doctor's job here, [also] the blood extraction..."

ID/F1.6/16mUK/YesOSExp

Two of the Indian nurses mentioned very proudly that back home they used to perform complex techniques, which are normally performed by doctors in India. Now they find themselves not even being able to apply techniques that are traditionally assigned to nurses such as IV administration of drugs or care of ventilated patients.

Similarly, some of the Filipina nurses working in an intensive care unit mentioned the frustration they felt due to the legal limitations on handling patients supported by artificial ventilation unlike their previous assignments abroad and in the Philippines:

"When we came here, we couldn't handle ventilated patients. You have to undergo some course but there [Middle East] no. Once you accept the job as intensive care nurse, you will handle these cases."

ID/F1.5/15.8mUK/YesOSExp

There were also some differences in perception about the role that the family of the patient should play in the care of their relative.

"...In the Philippines we allow relatives of the patients to stay with the patients the whole day and night, they are the ones doing the washes and

feeding while here it's a big change, because we are the ones doing it for the patients..."

ID/F2.2.4/52.1mUK/NoOSExp

Some of the nurses explicitly expressed their dislike of basic nursing care tasks that they considered hard as suggested by this nurse working in a haemodialysis unit:

"That's why I don't work in the ward because in the ward it is more stressful than here, because you have to wash patients. That's the most difficult; it is hard work. That's the hardest part of being a nurse."

ID/F2.1.4/46mUK/YesOSExp

Professional identity

An important part of the adaptation of IRNs is to adjust their own professional identity to the new aspects found in British nursing. The way managers perceive IRNs is an important element in the re-adjustment to their "new" professional identities. Some managers see IRNs as a short-term solution to the specific problem of a shortage of locally trained nurses:

"This Trust sees international recruitment as an answer to the vacancy problem they have at the minute. It is a short-term answer to a long-term problem and not necessarily a solution, and I think there is a place for it, but it shouldn't take prominence."

ID/Mgr.3/Br

Some managers perceive the reason for overseas nurses coming to the UK as mostly economic and tend to assume that the environment in which they were working before coming to the UK is far worse. As a result of these perceptions they are sometimes sceptical about what these nurses can add to the existing workforce:

"...They come here to send money home, to support, lots of them have children abroad, and a lot are here only to maintain and support people at home. [...] The level of healthcare there is far inferior to what it is here, they just walk into intensive care and you know? Oh! - We haven't got this equipment- they walk into here and it must be like another planet. [...] We need people to come and help us develop our service, not just come and provide a service. That is what sometimes we are failing to see with these international recruits, their contribution to the development of nursing..."

ID/Mgr.3/Br

Most managers saw the Filipino nurses as hard workers:

"... The Filipinos are very good, very hard working and most of them are quite dedicated to the work and they want to learn and they want to give as much as possible"

ID/Mgr.1/OS

However, Filipino nurses were also labelled as obsequious and lacking initiative by western standards:

"Well, the Filipino nurses, they are a very subservient culture, they are quiet, they need a lot of directing, and, they are very much "people-pleasers" They will run around and do everything for everybody else, if, they allow themselves, so sometimes they feel like a doormat..."

ID/Mgr.4/Br

Nurses in this study attached a special value to the uniform as a symbol of their profession. Particularly Filipina nurses referred to the custom of wearing their uniform out of the hospital in their own countries. Being well recognised by their uniform gave them a feeling of pride and some reported receiving some priority attention when queuing in shops and for services. This is uncommon in the UK because of infection control issues, but these nurses regretted that they could not wear their uniforms outside the hospital and perceived this as an indication of lower social recognition of the nursing profession.

Organization of nursing care

Another area that influences the construction of the professional identity of nurses is the organization of work in the wards. There are some disparities between the way the work is distributed and managed in India, the Philippines or previous migratory destinations to that in the UK. Nurses coming to work in the UK have to adjust to these new patterns.

In the Philippines nurses described an organizational model based on the American system, which is task-oriented. Each nurse is allocated one task or area of care like drug administration, record keeping or basic care. In the UK the organization of the work is

patient-oriented. Each nurse is assigned to a number of patients assuming all the responsibilities of care.

"Here we do primary nursing, like we have three patients [assigned], back at home its different, there's one in-charge and no patients [assigned], we just look after everybody. There is one medication nurse for all the patients; so, it's just quite different here."
ID/F2.1.2/46.5mUK/NoOSExp

In the UK shifts are also different from those in India or the Philippines. In their countries they divide the day in three eight hours shifts, in the UK two long twelve hours shift is the norm. Nurses recently arrived reported having had difficulties adjusting to this schedule:

"First of all I was feeling bad because we never used to do 12 hrs duties, we were used to do 8 hrs duties but anyway, I am now getting adjusted. First of all it was very difficult for me, but now it is okay, because we are getting adjusted with the routine."
ID/Id5/2mUK/NoOSExp

This work schedule allows for more free time during the week. IRNs often prefer to use some of that free time to do extra work and top up their salaries with extra work particularly when their families are not with them:

"I am doing bank [extra shift] today, because I have got 4 days off, so what are you going to do? You just stay at home? No, you better work!"
ID/F1.4/15.8mUK/YesOSExp

Some nurses from both India and the Philippines found that the workload in the UK was lower than what they were used before.

"There [in India], workload is very high, only few nurses are there..."
ID/Id1/1dUK/NoOSExp

"In the Philippines [the workload] it's really heavy."
ID/F1.4/15.8mUK/YesOSExp

Interpersonal relationships at work

Berry et al. (1989) argue that social interaction of people arriving in a new culture is as important as keeping elements from their own culture (Berry et al., 1989).

Relationships with colleagues, senior staff, doctors and patients were perceived by most of the nurses interviewed in this study as following different patterns than in their countries. That was something most nurses found very difficult, in particular during the first months in the UK, as suggested by this nurse while recollecting her experience after arrival, one year before being interviewed for this study:

"Adapting to people is not easy. Because people here is really different [lowering the volume of her voice]; sometimes you cannot please everybody, but I found it hard; I didn't know what they wanted, really, I couldn't get from them what they wanted us to do, because sometimes they are looking at you and I don't know how to approach them. It was really hard to read people..."
ID/F1.5/15.8mUK/YesOSExp

However, this perceived miscommunication could have originated in the different approach to nursing on both sides. While in the UK, nurses work mostly on their own initiative, back in India or the Philippines they need to understand what other professionals want them to do rather than deciding themselves and doing it. Nurses in the UK are expected to use their own initiative and to act according to their professional knowledge, while in India and the Philippines nurses reported working under the orders of doctors. This hierarchical system limits their professional capacity for decision-making resulting in overemphasising the importance of technical abilities over professional scope. Technical capacity replaces other more essential professional aspects.

Having gone through the initial shock in which they describe themselves as sometimes unable to maintain a normal relationship, Filipina nurses tended to adjust to the local interaction and most reported a positive perception of it. They almost all agreed that they enjoyed better professional relationships within the UK compared to these in either the Middle East or back in the Philippines. A more horizontal interaction, particularly with doctors, was identified as important:

"In the Philippines you wouldn't have the guts to say anything to the doctor, you would just follow whatever the doctor orders, and that's the one thing different. I mean, here you know you could mingle with the doctor, you could laugh with the doctor, you could eat with the doctor, or during teas or the

break time, umm, you could converse to them in a very casual manner. Back home we really treat doctors with a very high respect."
ID/F2.2.1/55.4mUK/NoOSExp

Something similar occurs with the relationships with senior nurses. In their countries they address senior staff by their title, while in the UK is common to use first names.

"...We had good relation with colleagues over here, there [in India] you have to respect seniors, when you see [a] senior you have to stand up and we should not talk in front of senior we have just to give much more respect. But here it is like everybody is friendly and we feel [that] persons are more approachable, over here we can go and tell whatever we want but there we were a little bit scared of what they will think."
ID/Id5/7.8mUK/NoOSExp

In this example, when the nurse speaks about respect there is a sense of subordination. Managers perceived this as uncomfortable and as a barrier for adaptation:

"If they just come from abroad you find that they are a bit withdrawn and don't know what to do and I think because they see you as somebody who is senior and there are certain things that senior people abroad don't do and they don't expect."
ID/Mgr.1/OS

Some IRNs perceived their relationships with patients as difficult and believed that they were treated with disrespect, not according to the deference they deserved:

"...[Back home] patients and relatives have a very high respect for nurses, which sad to say, doesn't seem to be happening here... umm, sometimes, patients and relatives treat you differently, as if you have to give service to them, as if, we were doing this job just because we are being paid to do so. They don't seem to give us respect, as you know, we are responsible for their life, we are responsible for their health and well being and its not just the money that we are here for ... "
ID/F2.2.1/55.4mUK/NoOSExp

Cultural disparities

Nurses in this study reported signs of stress due to changes in their cultural references and to the exposure to new references unknown for many of them. Following Winkelman's definition, this situation can be defined as culture shock (Winkelman, 1994).

Asian cultures are eminently collectivist as compared to Western cultures which are more individualistic and tend to be more self-centred (Pilette, 1989; Lopez, 1990; Yahes and Dunn, 1996; Kapoor et al., 2003). In this regard nurses often mentioned that in the UK they found people cold and disengaged with other's problems:

"... Nobody talks to others here, in India it was not like that, you know? If you go on the road and you sit down it means you have problems, so, many people will come around you, and they will ask you, what is the problem? Or what we can do for you? Here nobody will bother, they will just pass around, that's all, emotional attachment is very low here, I find."

ID/Id1/1.6mUK/NoOSExp

They saw British society as more liberal, in that it approved of issues that did not fit with the IRN's moral values. Disparate cultural aspects are sometimes perceived as a threat, particularly when they affect essential values, as this Filipina nurse expressed:

"...They are much more liberal than I thought, that's all. They are much more open to the sexual things, divorce is applicable here, abortion is applicable here but back home it's not."

ID/F2.2.4/52.1mUK/NoOSExp

Some of the managers explicitly reported culture shock as an obstacle to overseas nurses' adjustment. In order to overcome culture shock, socialising with the predominant culture is meant to be a good strategy (Berry et al., 1989). However, nurses coming to the UK from different cultural backgrounds found it difficult to follow British social customs:

"Actually I had a very good social life in the Middle East, but here, I don't know why, because, in the first place, we are not drinkers, we are not smokers, we don't usually go to the pub, but we go to the party, we always had parties there [in Middle East]."

ID/F2.1.4/46mUK/YesOSExp

It is noteworthy that this nurse suggested that in Saudi Arabia she had a very good social life although it was a frequent complaint among nurses coming from the Middle East that the social life they had was poor. This may be explained by the fact that back in Saudi Arabia nurses lived together in the hospital compound, with limited and supervised mobility, and in almost complete isolation from the local culture. They

worked in an entirely international environment, in which the only representation of the local culture was the patients and a few staff. In such a closed environment, social networks were more available to provide support. The complaint from this nurse could be the result of comparing the supportive environment that she had in Saudi Arabia with what she perceived as an incompatible social environment in London.

As a result of these perceived limitations nurses often felt isolated. A feeling of loneliness was mentioned in most of the interviews of nurses who had arrived during the last two years:

"I moved out of the residence with an Indian family. I was missing my family and I was alone at residence so I thought maybe something different, I can mingle with them, I can have dinner or lunch with them but they just consider me as a renting person and they are not ready to mingle with me. I am finding difficult really still I feel lonely over there..."

ID/Id5/7.8mUK/NoOSExp

Bullying and discrimination

Winkelman (1994) suggests that people arriving in a new culture should be prepared to feel rejection, prejudice and discrimination as a result of the ethnocentrism of host cultures where members believe that their cultural ways are superior (Winkelman, 1994). Racial discrimination that prevents staff from ethnic minorities advancing in their professional careers is broadly documented in the NHS (Sheffield et al., 1999; Shields and Price, 2002; Randel, 2003; Gerrish and Griffith, 2004; Smith et al., 2006).

The reasons for discrimination are associated with different factors. Some of the nurses explicitly identified race as the cause of discrimination as suggested by this Indian nurse:

"Is the supervision and how they behave to us, the discrimination to some people there are so many things, some people is racist, there is all kind of discriminations going on but you can't, you know after a while it seems that there is nothing but there is. I don't know about the whole hospital but in [name of unit] there is. I am still thinking that I have to leave the hospital."

ID/Id7/7.8mUK/YesOSExp

The same nurse reported that discrimination was also affecting a Spanish nurse:

"So two have left just for that reason to [name of other hospital]; one is Spanish and the other is Filipino. They left because they finished their course two years before and they were not given an F grade but there are people who have finished and they're Irish or British just finished and they are offered F grade straightaway. They say that your ability to manage is not enough, well how can you prove that?"

ID/Id7/7.8mUK/YesOSExp

The implication of the above is that discrimination is not just based on race but on "foreignness". The fact that Australian, New Zealand and Irish nurses are treated better might be related to their closer cultural compatibility particularly reflected in their use of English. This is validated in other studies about discrimination against foreign nurses in the British Health Services (Allan et al., 2004).

Some of the nurses reported having been discriminated against in previous migratory destinations, which made them more sensitive. This Filipina nurse who worked previously in Saudi Arabia said:

"Because they are white people, you know the Saudis look white people higher than any other nationality. So that is the problem in Saudi."

ID/F1.3/15.7mUK/YesOSExp

Discriminatory attitudes are not only perceived to come from colleagues and managers but also from patients:

"I think they (patients) treat British nurses differently, I think they have more respect to British nurses than to overseas nurses, I don't mean that they are racist but but, umm, there is a difference."

ID/F2.2.1/55.4mUK/NoOSExp

Another aspect that has clear implications for the process of adjustment is the experience of aggressive and negative behaviour from colleagues, patients or other staff members. One Indian nurse reported having been bullied by a senior nurse who degraded her in front of a doctor:

"The doctor was discussing with the senior nurse and then you know the senior nurse told him - she is just new she don't know just don't listen to her - in front of me. That's too bad isn't it? I don't think I will ever do that. That's the way, this way anybody, nobody will tolerate, it can be British or anybody,

anybody will tolerate. Then after that he [the doctor] was not coming to discuss anything with me because he thinks that I don't know anything and I am just junior so I can't say anything."

ID/Id7/7.8mUK/YesOSExp

Another nurse felt harassed by her mentor, who was an overseas nurse herself:

"I was on nights, the first day itself, I had induction during the day and I was on night duty with her, and she was teaching me many things together, and she told me something and I did a mistake and she got so angry, she told if you are like this, you won't be able to learn. I was feeling so sad that I was crying all next day."

ID/Id5/7.8mUK/NoOSExp

Nurses are also sometimes victims of bullying from patients and relatives. One of the Filipina nurses reported that in her experience it was overseas patients who were the most likely to behave in this way:

"I really don't want to be a racist but like, like for example say Asian patients and Asian relatives, say Bengali or Indian or Pakistanis they are demanding in some ways, umm, but they doesn't seem to understand that, umm – I mean, they would demand like, very simple things, even things which are not related to nursing at all. If you are not very careful you could get bullied from relatives as well, perhaps, I really don't know what the reason is for that."

ID/F2.2.1/55.4mUK/NoOSExp

Bullying was identified and acknowledged by the RCN as a problem in its report "Work Well" where Black and Asian nurses were 50% more at risk of being bullied than their white colleagues (RCN, 2002a). Bullying and harassment is often under reported (Randel, 2003). Half of the nurses surveyed by RCN in 2002 who had been victims of harassment or bullying from patients or relatives did not report the case (RCN, 2002a). Other nurses within the group involved in this study might have suffered similar experiences but not reported them, fearing repercussions in their careers in the UK.

Coping with difficulties during the adaptation process

Many of the nurses interviewed in this study were having difficulties integrating into British culture. Winkelman (1994) suggested that in order to manage culture shock and promote acculturation appropriately it is necessary to have maintenance and reparative behaviours (Winkelman, 1994). This is to keep original behaviours at the same time as

exploring the new culture. Eating food from one's own country, talking and interacting with people from same country, or making phone calls home are some of the behaviours proposed to fight the stress generated by culture shock.

Some of the nurses involved in this research, especially those who have been in the UK for less than one year suggested having little social life or contact with British culture limited to interaction with British colleagues in the workplace:

"No, I'm not getting into the culture really; I still eat my rice and fish curry. No, I don't like the culture really. I follow everything as in India I like to be an Indian even if I live in England I did not go out, I did not go anywhere, I have only gone to Oxford Street. No, really I just visited [Indian colleague's name], she's got three kids, and they are really nice. I just use to visit her and go to some of her friends', [otherwise] only work and home."

ID/Id5/7.8mUK/NoOSExp

Even those nurses who had been in the UK for over one year suggested limited contact with the local culture, other than in the workplace. Even there, they tended to limit their contact to the other Filipino staff:

"...Here [in the ward] is nice, we are so many Filipinos! That's the only thing, but if I was assigned in the floor [ward] with these westerners [British], so I would feel that I don't belong."

ID/F1.5/15.8mUK/YesOSExp

Often they organize social gatherings among the Filipino staff in the hospital and eventually they invite their mentors and supervisors:

"So every weekend we have time to gather around, all the batch mates gather around on Fridays or Saturdays, and we have some sort of a party, which you know, kind of help us to get over the boredom in here."

ID/F1.5/15.8mUK/YesOSExp

To avoid isolation these nurses often tend to increase communication with their relatives back home. They use the Internet and also mobile telephones:

"I phoned them almost everyday... I had to buy loads of cards to phone them almost everyday. I think that was for about two months or so, yeah, calling them every now and then."

ID/F2.2.1/55.4mUK/NoOSExp

Sometimes the cost of keeping links with their relatives at home had financial repercussions:

"I had this problem of meeting my financials to the end [of the month], because I ended up spending loads on my phone."
ID/F2.1.3/46.5mUK/NoOSExp

Social networks play an important role not only in attracting nurses to the UK but also in supporting cross-cultural adaptation. However, in order to promote adaptation, relationships with members of the host culture should be supported with relationships with people from other cultures sharing similar experiences (Furnham and Bochner, 1986). The fact that they come in cohorts is perceived as a good source of support, in particular during the first difficult weeks in the UK. Many of the nurses interviewed expressed support from the rest of nurses in their same situation:

"In my first months here, during my free time, I just stayed home. It was a Trust accommodation. All the nurses who came from the Philippines [with me] were there. That itself is a community of Filipinos, so if ever I wanted to see someone or just speak to someone, I could just knock on their door."
ID/F2.1.1/47.6mUK/NoOSExp

One strategy used broadly by nurses participating in this study to cope with the uncertainty generated by the difficulties in adapting to the new environment is short term planning. Most of the nurses have no clear idea about their plans beyond four years. The most frequently reported plan was to stay in the UK until the end of the current contract and then assess the situation as suggested by this Filipina nurse:

"I will finish this four and a half year's contract and then during this period we will see how it goes, and then from there we will see."
ID/F1.5/15.8mUK/YesOSExp

Chapter summary

This chapter presents first the different phases in process of adaptation of IRNs to the UK environment. Then the Overseas Nurses' Programme has been introduced as well as some findings about how the experience is perceived by these nurses in particular the mentorship element. Findings that show the weakness of the programme as a skills

assessment tool has then been introduced. The chapter then presents the barriers perceived by IRNs and managers to the process of adaptation. Problems with communication, different professional perspectives and cultural disparities are the main source of problems as expressed by these nurses. Finally, the strategies followed by these nurses to cope and manage these problems have been illustrated.

Chapter 5: Expectations, Experiences and Plans

Introduction

As presented in Chapter 1 there is evidence in the literature of a relationship between information provided to IRNs' pre-departure and the development of expectations and between met expectations and job satisfaction. The decision to emigrate is influenced by push and pull factors. Pull factors as reported by the nurses involved in this study are a good representation of their expectations. This chapter presents the expectations developed by the nurses in the economic and professional areas followed by their experiences in the same areas in order to assess to what extent expectations are met. It also presents other professional experiences that were not expected by nurses but which represented a source of job satisfaction for them. Problems faced by nurses with career progression and their future plans complete the results of this research.

Expectations development

The most valuable data about expectations development was collected during the interviews of Indian nurses the day after arrival in the UK and from the Trust managers who went to India for recruitment.

The information that nurses gathered before their departure from either India or the Philippines was important for the development of expectations. Interviewees said that a main source of information were friends. One of the nurses in this group said:

"I heard so much from my friends that it is better here of course."
ID/Id1/1dUK/NoOSExp

Or this other nurse interviewed also a couple of days after arrival in London:

"I got some information from my friends about UK. Life will be busy, weather will be different and also all habits will be different, and the duties and everything."
ID/Id2/1dUK/YesOSExp

Some of the Filipina nurses suggested that having been in other countries they imagined London as similar:

"Because I have been to U.S., so I thought it will be just the same like big roads, big buildings..."
ID/F1.5/15.8mUK/YesOSExp

Others mentioned TV and movies as a source of information from which they developed some expectations with regard to environmental details like the urban landscape or the climate or even the physical appearance of the hospital where they were going to work:

"We would see like hospital settings in the television or in films and they are kind of modern and hi-tech, I thought London is also like that."
ID/F2.2.1/55.4mUK/NoOSExp

Having been selected, some of the nurses reported having had a briefing session about London, the Trust and what they could expect to find there. One of the Filipina nurses recruited in 2003 expressed her perception about the main objective of this briefing session:

"During the interview, Peter [from Trust's recruitment department] was telling us about London, about the Hospital and what were the things that we could expect there. That was the priority of the interview itself because is like a briefing just for us to feel comfortable..."
ID/F1.1/15.7mUK/YesOSExp

The group of Indian nurses responded that they did not get enough information about the conditions in which they were going to be living during their adaptation period:

"The market prices are very high here. The salary should be higher, and one more thing, you know in India they used to give us the residential quarter, that is at a very cheap rate. Hospital residence should be very cheap, but here it is very expensive. [IV – Do you think that if they would have informed you in India, how things were going to be here, you would have taken a different decision?] Yeah, I wouldn't have come. [IV – Wouldn't you?] Not at all"
ID/Id1/1.6mUK/NoOSExp

Sometimes the information was misleading. When nurses asked about the physical appearance of the Hospitals, they were advised to look on the Trust's web site, which only shows how the buildings will look 10 years hence when its refurbishment will be finished. Also there was insufficient detail given of working conditions:

"When we had our interview we were told that it was 37.5 hrs per week, but we were never informed that it was 12 hours shifts... From India we used to listen we would get so much of salary but after coming here we came to know it is nothing... About the hospital they were giving no information, because they were giving us the website to look up at the hospital."

ID/d5/2mUK/NoOSExp

Trust managers involved in the in-country selection of nurses perceived the role of the local recruitment agency in providing information as unsatisfactory:

"In theory they would have been briefed by the agency just before we started interviewing, and actually during the course of the first morning it was becoming obvious that people's ideas of where they were coming to, was really not particularly accurate... that's what they had been told and actually the agency had this glossy pictures of Buckingham Palace and Tower Bridge and the Houses of Parliament and that's what they were given to look at during the briefing session."

ID/Rec1/B

The evidence found in this study validates the findings by other researchers that limited or inaccurate information provided before departure often leads to the development of unrealistic expectations which have further implications for adaptation (Fritsch, 2001; Johnson and Oldham, 2001; Buchan, 2002b; Allan and Larsen, 2003; Buchan et al., 2003).

The expectations and experiences suggested by nurses in this study have been grouped in two different areas: economic and professional.

Economic perspective

As shown in Chapter 3 economic motives are always, but not exclusively behind the decision to emigrate. There is often a considerable difference in salaries between countries of origin and destination. The average monthly salary of a nurse in Philippines and India is similar and is the equivalent of about £78⁴. The average basic monthly salary of a nurse working on band 5 (junior staff nurses) in Britain is approximately £1,730 (NHS, 2004). However this comparison does not account for the disparities in

⁴ [<http://news.bbc.co.uk/1/hi/health/3191525.stm>]

the cost of living between their country of origin and the UK. In a Worldwide Survey of Cost of Living, out of 144 surveyed main cities around the world in 2005, London ranked 3 while New Delhi ranked 110 and Manila 143 (MGIS, 2006). Economic expectations are often not met during the first year. There is a feeling of frustration in this regard that was expressed by most of the Indian nurses during their interviews. This is more remarkable and noticeable during their first months in the UK when salaries are low and expectations are still high. Most of these nurses, during the ONP, were receiving a salary corresponding to a level C grade unqualified nurse in the NHS salary scale (around £15,000 net per annum or £1,250 net per month). The Trust provided relatively cheap Hospital accommodation to these nurses during the first months. Nurses had to pay £365 per month for one single bedroom in a hall of residence. Despite all these inputs from the Trust, this group of nurses felt that their financial situation was precarious. The nurses who had been in Middle Eastern countries felt unable to save as much as they were saving there as this Filipina nurse suggested:

"Its really expensive life here, because you have to pay for your house over here, but in the Middle East, we didn't think on that because everything was free".

ID/F2.1.4/46mUK/YesOSExp

It seems that nurses learned to cope with the economic situation during the process of adaptation to the UK. There was a process of re-adjustment of expectations demonstrated by the fact that economic constraints among nurses with longer experience in the UK were not referred to as often as among those newly arrived. Besides the objective of supporting relatives through sending remittances home, Filipino nurses often emigrate with the objective of achieving improvements in their socio-economic status back home in the Philippines. In that regard most Filipina nurses came to the UK with economic targets. When speaking about them, these targets were normally not expressed in monetary terms but in terms of investment in business or property. Some expressed openly their intention to stay until they reached such targets after which they were planning to go back to the Philippines:

"I want to start a business back home and as soon as I have enough money, enough guts, as far as I have gained enough experience here, umm, I don't think I am going to stay here for long, I still really miss back home..."

ID/F2.2.3/52.5mUK/NoOSExp

Similarly other Filipina nurses spoke about their plans of starting business back in the Philippines in different sectors:

"...A "piggery", and chickens, I want a farm... yeah. My sister has already this apart-hotel, like a hotel with 50 rooms and I want also to buy."
ID/F1.3/15.7mUK/YesOSExp

"...Yes, maybe, this year; computers shop..."
ID/F2.1.1/47.6mUK/NoOSExp

"... Making plans yeah, build a house like a home, yeah, while I am here and still working, maybe a car and a business..."
ID/F2.1.3/46.5mUK/NoOSExp

"... Yeah farm business yeah."
ID/F2.2.2/51.8mUK/NoOSExp

Nurses undertaking the Overseas Nurses' Programme (ONP) were getting paid as unqualified nurses. After some time in the UK nurses realised that the initial expected economic benefits obtained by working in the UK were only relative, given the high cost of living in London. However the strength of sterling compared with their local currency was often mentioned as a relative incentive:

"...You earn more here, but you also spend more, but comparing to the standard of life, here it is much better..."
ID/Id7/1.5mUK/YesOSExp

There is a difference between Indian and Filipina nurses in this respect. While Filipina nurses reported sending money home to support their families, Indian nurses expressed a different attitude. Out of six Indian nurses only one was sending money back home and that was more related to personal matters rather than supporting her family's economy. Indian nurses were getting a fraction of the salary of a registered nurse during the ONP, which could also have undermined their capacity to send remittances.

Having been working as senior nurses in their countries of origin allowed them to live with relative high standards:

"What I'm saying is, back home I have a very good house. ...He [my son] is in an English school, a very good school. St. George School is a very old

school, it was opened during British time, and so that is a very good school. ...There I was the most in-charge, the most senior [nurse]. I was getting 25,000 Rupees. It is not a very small amount, you can say."
ID/Id1/1dUK/NoOSExp

However some found that their quality of life was relatively lower in the UK. The same nurse narrated her perceived worsening of living standards since she arrived in the UK:

"I am living in a house with my husband and my son. We are in one room; we are just sharing a house and all that. Sometimes we ask ourselves what we have done. Why did we leave that? He [her husband] hasn't got a job still now, he is sad, because he didn't get till now a job, because back home he was a pharmacist but here they don't accept that pharmacist title, and he is quite an aged person, you know? Wherever he is trying they are not... he is in his 50s, so he is not... that's also making him worried as well as to me."
ID/Id1/1dUK/NoOSExp

In her study about the migration of Filipina women, Hochschild (2003) suggested that it was common among Filipina migrant women to leave their children at home under the care of the mother (Hochschild, 2003). Another study found that Filipina nurses with children were not planning to bring them to the UK (Daniel et al., 2001). In this study the four Indian nurses with children had already brought them to the UK while among the five Filipina mothers two had their children in the UK and three in the Philippines.

In the Philippines, the decision to emigrate is often a family survival strategy. Families support daughters and sons to undertake nursing studies and to emigrate as a strategy to improve their economic status through remittances. Some of the Filipina nurses reported having studied nursing against their will and some even having left the Philippines reluctantly:

"...If [it was] only for myself, money wise I can live with that, [but] because I have a family to support, my brothers and sisters are still in school, so that's the reason, so why not grab that opportunity? But I hated going overseas at that time, I was still young, I was only 24..."
ID/F1.5/15.8mUK/YesOSExp

The primary beneficiaries of remittances are the family unit of the nurse but that responsibility often includes extended family like parents, brothers, sisters and sometimes cousins as this Filipina nurse suggests:

"...It's a big step for you to leave the kids especially, but at the same time, you have to think about the money, about that you will be able to finance your children, my children's education and then you can give them a better life, and you have to send as well for your brothers and sisters. Unlike here the scope, the scope of family is so big! When you say family it involves everyone, also your cousins, sometimes you have to finance their studies and anyone who is basically in need." ID/F2.1.3/46.5mUK/NoOSExp

The group of Filipina nurses who had been working in the UK for around four years suggested their remittances were on average 5% to 25% as a proportion of their monthly salary. This is lower than the 50% reported by London IRNs in a study published in June 2006 (Buchan et al., 2006)

Professional perspective

It is in the professional environment where IRNs find the greatest challenges in the process of adjustment, especially during the first two years after arrival. Their professional skills were the asset for which they were recruited. Professional expectations generated during the process of recruitment were sometimes not met. However there were professional experiences that were not expected that represent a source of professional satisfaction such as better professional development opportunities, relatively better access to material and modern technology, and relatively better standards of care.

Greater opportunities in the UK to develop themselves professionally represented a very strong motivator consistent with their expectations:

"I can study, I can concentrate on the study, here there are many, I heard there is lot of trainings, free trainings, so I will avail of that."
ID/Id1/1.6mUK/NoOSExp

"I feel that NHS is an organization which can help the nurses to develop their knowledge as well as their career..."
ID/Id3/2dUK/NoOSExp

However, despite being eager to upgrade themselves, there were some factors that were perceived as hindering those prospects. Not being able to use their abilities was found sometimes frustrating:

"When you have already been doing the same work back home and suddenly you are blocked by everything, I mean you are not supposed to be doing all this and your are not supposed to give medicines and you are not supposed to do that and you are not supposed to do this, because you are still under supervision, that gives you a kind feeling like uselessness, you feel yourself as a useless person."

ID/Id3/8mUK/YesOSExp

Apart of the loss of these skills in the NHS, one important implication of the above is that nurses feared becoming de-skilled, which was particularly important for those who were planning to move forward to another country where they could use these abilities:

"...It's frustrating because you have to think that if I don't like this place and I want to move on, will miss all these skills because you don't practice this that much now."

ID/F2.2.2/51.8mUK/NoOSExp

Some of the nurses involved in this study suggested that excessive specialisation in the UK leads to poor quality of care. Using skills only in their area of specialisation is perceived as impeding a more holistic approach. It also adds to their fear of deskilling. Some suggested that when they came to the UK they stopped using what they considered general nursing skills and performed only in the area of specialization to which they were assigned:

"My biggest disappointment is the nursing practice. Here, when you are a renal nurse, I don't doubt them, they are very good, when it comes to renal 100% they are very good, well skilled, they know everything. When you are cardiac nurse you are very good, only in your field, that's the thing. But you should learn everything, the basics. I don't know, it's the way I was trained, the basic skills in nursing you should know everything, you should have an idea. I was working in an ITU and you know the practice, and then we come here and all of a sudden everything has been cut out for you, you don't do that here, and sometimes you loose these skills because you don't practise it anymore, that's one thing, disappointing really."

ID/F2.1.3/46.5mUK/NoOSExp

Most overseas nurses arriving to work in the UK start working in the lowest professional levels regardless of their previous experience. Sometimes there was a perception among nurses involved in this study that managers and peers underestimated their skills as suggested by this Filipina nurse:

"...Sometimes these sisters can intimidate you as if, the feeling is, the true feeling is that they seem to think that you know nothing..."

ID/F2.1.3/46.5mUK/NoOSExp

Some nurses suggested that they were disillusioned with the reality in relation to the standards of care in the wards:

"...What we can see here is that, one or two weeks after surgery, all patients come with an infection or any other thing... [Back home] we were more strict with infection control. When we thought of London, we were expecting very good standards but we are not finding anything like that."

ID/Id5/2mUK/NoOSExp

Similarly expectations regarding access to material and modern technology were expressed. Nurses, particularly these coming from Middle East or from private institutions in India or the Philippines, found the material and technology similar or worse than that they had been using:

"I was expecting that nursing here was high standard, I mean equipment wise I thought that their equipment is new and upgraded, very high tech and when I found it out is just the same we have got back there in SA, some of it is a bit old and we lack some equipment, we run out of supplies like that, so that makes the expectation a bit discouraging, I mean you are expecting high and find it out that is not really the one you expected."

ID/F1.1/15.7mUK/YesOSExp

Unexpected experiences

There were some areas of practice that despite not being expected were perceived as positive and enriching such as professional autonomy, patient's involvement in care and treatment and the emphasis on evidence-based nursing.

Regarding professional autonomy it was suggested by many participants that nursing in the UK was a different experience in this regard. What they found in the UK is that, unlike in their countries of origin, their initiative and opinion was taken into consideration, making a difference to their perception of professional practice as suggested by this Indian nurse with no previous experience abroad during her interview:

"...Here we have got a chance to decide on our own, what we can do for the patient, and, the doctors ask you on rounds what's your plan for the day. That means he is ready to consider us and he is ready to consider our knowledge.(...) I am now much more afraid to go back to India and work there, I told you is more doctors oriented, and after working here we go back to orders to do this, do that and we may not be able to tolerate that."

ID/Id5/2mUK/NoOSExp and ID/Id5/7.8mUK/NoOSExp

Another unexpected experience that was perceived as positive by most nurses was the communication and involvement of patients in the nursing care. In particular most of the Indian nurses suggested that information was given to patients about procedures and that patients were given choices, unlike in their country:

"...Here we can see that they explain everything to the patient, and they are getting cooperation, full cooperation from the patient and they keep informing the patient whatever they do, but there it is not like that..."

ID/Id5/2mUK/NoOSExp

Another aspect of nursing care standards that was considered positively was the fact that nursing is evidence based:

"They're more on studies; they're more on evidence based care..."

ID/F1.2/15.7mUK/YesOSExp

Career progression

One of the concerns reported by senior managers at the Trust during initial contacts to present them the research proposal was the high prevalence of career stagnation among nurses recruited internationally. Nurses actively recruited overseas were not progressing in their professional careers as expected. This was creating some gaps in the workforce resulting in the need to use quite high levels of senior agency staff. Because of the Trust's concern, all nurses in this study were asked about their plans for career development and the experiences they were having in this respect. All Indian nurses interviewed were eager to pursue career progression. Within the Filipino group however all those with around one year experience in the UK expressed their reluctance to progress further. In the group of Filipina nurses with around four years experience in the UK, those in junior positions were all reluctant to pursue advancement, while most of these in more senior positions were eager to continue their progression.

Shields and Ward (2001) suggested that dissatisfaction with career development and training opportunities among nurses in the NHS in England were strongly linked to intentions to leave the profession (Shields and Ward, 2001). Interviews suggested that the problem perceived by the Trust was quite complex. The reasons given by nurses in this study can be grouped into two perspectives: individual and institutional.

Individual perspective

At the individual level many of the nurses, particularly those who had been in the UK for four a half years and who were still holding junior positions, suggested they were not ready to assume positions of responsibility due low self-confidence:

"... Right now I don't want to because, I don't feel like that confident to carry on with it, but I'm happy how things are going with my life at the moment and my career..."

ID/F2.1.1/47.6mUK/NoOSExp

Others perceived a lack of knowledge about the system to the level required to hold managerial positions like this other Filipina nurse:

"I don't want to rush the position and then somebody junior to you tells you how to do things. I wanted first to study, [to make sure] I get everything [all skills], I am well prepared. I don't want to be told that I was not well prepared."

ID/F2.1.3/46.5mUK/NoOSExp

Nursing practice in the UK is mainly based on scientific evidence. This requires that nurses are continuously updating their knowledge. Some of the Filipina nurses felt they were not sufficiently prepared in this respect, which made them perceive that they would not be able to succeed in interviews for promotion.

"Here you have to read something, because people are working always seriously. There are always changes so I have to read something about this or about that. Everything that you are doing, there is rationale behind. In the Philippines you are not always studying, as long as you are doing okay, but here you have to know it deeply."

ID/F1.5/15.8mUK/YesOSExp

Having to deal with staff issues, especially when it is about conflict management requires a strong personality. One of the nurses that had already progressed from D to E grade decided not to progress further to avoid stress:

"Because if you are F Grade you have to deal with all kind of problems on the ward, especially problems with the staff, so it is quite stressful. So I have not accepted those offers."

ID/F2.2.3/52.5mUK/NoOSExp

Most of the Filipina nurses explained their reluctance to progress in their professional career claiming that they didn't want to get separated from the bedside nursing work:

"...Actually most Filipinos they don't aim too much to high grades. We like taking care of the patient, we want bedside better than managerial positions."

ID/F1.3/15.7mUK/YesOSExp

Other nurses simply said that they were satisfied with their present professional status and were not planning to progress:

"I am alright being a D Grade; I don't feel like I am stagnating ..."

ID/F2.1.2/46.5mUK/NoOSExp

Another Filipina nurse, despite expressing satisfaction with her present professional status in the UK, was also frustrated at not being able to use some of her skills:

"We are D grade and we can't have those patients' with ventilator. God, I miss that work! The first time I went back home, I visited my previous work, a medical intensive care unit, to look up what they [her former colleagues] were doing because I missed it. There are times that it pushes me really to apply for higher positions, but I don't think I... I really want to."

ID/F2.1.3/46.5mUK/NoOSExp

There were some nurses who suggested that the economic incentive for progressing from junior to more senior levels was not strong enough for them to pursue such positions.

"I think some nurses don't like to go for promotions. It is not much difference really in the salary. Between D and an E there is not much difference, unless you do what we call cable here, go for some bank work."

ID/F2.2.2/51.8mUK/NoOSExp

Implicitly this illustrates a trade off between the efforts of assuming new responsibilities and having to go through courses and the economic improvements. The two following quotes come from interviews with two Filipina nurses at different stages of their adaptation process; the first one had been in the UK one year and the second for four years. Both answers were given having talked with them about their plans for career progression and their intentions to assume more responsibilities or not:

"I am satisfied with my salary; money-wise it is more than enough for me to be honest..."

ID/F1.4/15.8mUK/YesOSExp

"...As long as I meet already my goal, that's enough for me, I am satisfied with myself, I am satisfied with the money I am earning, I am helping also my family, that's enough."

ID/F2.1.4/46mUK/YesOSExp

In economic terms, progressing often translates into reduced opportunities to top up their salaries with overtime as this nurse suggested when talking about some of her Filipino junior colleagues:

"They say I don't care as long as I get to do a 9 to 5 clinic job, or do my Monday, Tuesday, Wednesday long-day and have the rest of the week off, so that I can do extra shifts and send more money to the Philippines."

ID/F2.2.5/54.7mUK/NoOSExp

Some of the nurses, especially older nurses, expressed difficulties undertaking studies:

"...It is hard to study, I am already old..."

ID/F1.2/15.7mUK/YesOSExp

"...In Ireland you are paid according to your experience, they don't have this grades, you are paid according to your experience unlike here where you have to study first..."

ID/F1.3/15.7mUK/YesOSExp

Another reason cited by older nurses is the fact that they were planning to retire soon as this Filipina nurse said:

"No need for me [to progress], there are younger colleagues, they need that. I am already going to retire, that's enough."

ID/F2.1.4/46mUK/YesOSExp

Many of the nurses that were not keen on seeking career progression had previously applied for higher positions but did not get promoted either because they were not called for an interview or because they failed it. This often made them feel insecure in applying again:

"I had applied before for the next step which is the E grade. I applied twice but I was only interviewed once but I failed. Then right now I don't want to apply again because I don't feel confident to carry on with it..."

ID/F2.1.1/47.6mUK/NoOSExp

"Well I did apply before but I failed, I don't mind."

ID/F2.1.4/46mUK/YesOSExp

Cultural adaptation plays an important role in the potential for career advancement among these nurses. The only nurse from the group of Filipina nurses with more than four years experience who had managed to reach a senior position beyond grade F, was someone who had emigrated initially to New Zealand where she worked as a nurse manager for nearly five years. The cultural distance between New Zealand and British culture is shorter than between the UK and India, the Philippines or countries in the Middle East, and in the interview, this nurse gave an impression of familiarity with British acronyms and values. She also had high aspirations from her time at a nursing school, when she wanted to become the nurse of the Prime Minister in the Philippines:

"I did nursing for my grandmother, and she wanted me to become a presidential nurse, because she reckoned that being a presidential nurse was one of the best forms of nursing that you can do. Because my aunt was a colonel and she was a presidential nurse. Do you know Marcos? Do you remember Marcos, the dictatorship? She was his nurse, so that was the dream you know to be something like that."

ID/F2.2.5/54.7mUK/NoOSExp

Institutional perspective

Some nurses implied discrimination as the reason behind their career stagnation. However reports of discrimination were based more on hearsay than on evidence. The most prevalent comment among Indian nurses was, having heard that there were double

standards applied to nurses coming from overseas and for British nurses, then felt hesitant to apply:

"...People say that is difficult for "the others" to get into the high jobs or high positions and that they always prefer the British..."

ID/Id3/8mUK/YesOSExp

"I don't know, because I heard that someone who is coming from other country like Asia or anywhere they just reach up to E and stop over there, then may not go up to G or F or anything, I don't know why is it."

ID/Id5/7.8mUK/NoOSExp

Having been trained in the UK was perceived as an advantage for career progression even by nurses with quite a long experience nursing abroad.

"I am really very lucky [for having been promoted], considering that I am trained outside. For someone who is trained here in London it's not very surprising, but for me, I would say, I am very, very lucky..."

ID/F2.2.1/55.4mUK/NoOSExp

The nurse above mentioned luck as the reason for her promotion rather than professional merits. The implication of the above is that the overseas nurses may have to rely on other factors than professional merits to achieve what local nurses achieve. The system for promotion is perceived by some of the nurses as arbitrary and subject to the subjective perception of the managers rather than to objective professional criteria.

One nurse told the story of other overseas nurses who had been victims of discrimination within the same ward:

"Two Filipino and one Nigerian finished the course two years ago. They were supposed to get F grade but they didn't get it yet. But there are people who have just finished and they're Irish or British and they are offered F grade..."

ID/Id7/7.8mUK/YesOSExp

Some of the nurses suggested IRNs experienced a very slow career progression compared with other British or even internationally qualified nurses from other nationalities (e.g. Ireland, New Zealand or Australia). Out of the five nurses interviewed from the group with more than four years of experience in the same ward and who wanted to progress up the professional ladder two of them were still holding an E grade.

Another institutional reason for these nurses not to have achieved higher grades is lack of institutional support. Some nurses expressed not having had enough support from their managers to apply for higher positions but often the key problem was insufficient staff to support nurses.

"And then [during the course] nobody encouraged you in our class, because of lack of staffing as well, we didn't have teaching practitioner to support us... Our sisters don't bother, sometimes you get disappointed because you are registered for a study day and then you get cancelled, because there is no staff available, which you understand our unit, you know we don't have enough staff, we lack so many staff, so that's been for three years now..."

ID/F2.1.3/46.5mUK/NoOSExp

The manager's perspective also suggests the same hypothesis. Having many agency nurses working in the ward, demands longer supervision time from managers that cannot be devoted to support IRNs.

"The senior staff work monitoring junior staff; so on a day to day clinical shift basis, they have support, but you have got to appreciate we are working within an environment with a high, amount of agency use, which may influence level of support [to IRNs]."

ID/Mgr.3/Br

Thus lack of support to develop was cited as one of the reasons not to progress up the professional ladder. Interviews with managers provided an interesting perspective with some suggesting strategies to promote career advancement among IRNs. Out of the four managers, one was an overseas nurse herself. Her attitude towards IRNs was found to be quite different from the other three British managers in terms of supportiveness and a positive attitude towards overseas nurses. Her attitude was proving to be quite effective in promoting overseas staff in her ward:

"...We've just interviewed a few Filipinos and they've gone up to F grade. I think what they need is encouragement... What I normally do when I work with D grades is to give them the E grade job description and I say look at it read it and see if you can work towards this and then we sit down, we go through the objectives and then we will pick up some of the courses that they need. Maybe they will need things like assertiveness and things like short managerial courses that are one or two days, you know just attend these courses ..."

ID/Mgr.1/OS

Planning the mentorship of new staff with her workers was found to be important. She suggested that doing so would not only help them to identify their training needs but also would help them overcome their fears and provide nurses with a perception of being valued which would have an impact on their willingness to progress in their careers:

"Ok, they are here to work and work hard, but I think appraisals are very important because they will help people to think that they have been valued and that their hard work has been appreciated and they need the reward of going up the ladder..."

ID/Mgr.1/OS

Some of the nurses mentioned that they held positions of managerial responsibility back in the Philippines but that they were not ready to hold them in the UK. One of the reasons for that is that the role of managers in the Philippines is different to that in the UK. For example, nurse managers in the UK, unlike in the Philippines, play a liaison role between different levels of the health system and are responsible to link to primary health care professionals for continuation of care after discharge of the patient:

"No I don't have plans [to apply for managerial positions]. Here is very different to be in charge especially in special care because those patients that are nearly going home, here you have to contact the health visitor, you have to contact GP, you have to contact everybody, especially if your patient is going home on oxygen or in NG feeding, so is very different for discharge planning meeting yeah we don't like stuff like that. Here is really a multidisciplinary team with the community nursing."

ID/F1.2/15.7mUK/YesOSExp

Also disparities in the organization of the work in the UK were perceived as a barrier to career progression and to assuming managerial responsibilities even among nurses who had been in the UK for four years. One Filipina nurse working in critical care, who found herself insufficiently prepared for the position suggested:

"... I said to our ward manager, you know sister? When we arrived here, if you had let me be in-charge and I got used to it, maybe there was a little chance for me to apply now and go up, but now I am used to be a D Grade and I am happy with what I am doing, I am always happy to interact with my patient, rather than changing beds' planning, you know? Less interaction with the patient? I don't like it! Maybe that's another reason why I don't want to go up."

ID/F2.1.2/46.5mUK/NoOSExp

The other three managers believed that their role in supporting promotion of IRNs should not be any different from that of supporting British nurses:

"I think the big thing is to ensure equal opportunities, ensure everybody is entitled to the same chances. And I think we are for that."

ID/Mgr.2/Br

One of the managers argued that the academic level of some of the nurses was not up to the level required. In this case the manager was not as worried about the level of knowledge but about the difficulties for these nurses to transfer skills between the practical and academic environments:

"Sometimes I don't think they are actually able from an academic perspective... They were very hardworking but they didn't transfer that over to their own development in the academic side of things..."

ID/Mgr.3/Br

However the fact that different educational systems produce different educational outcomes and that the preparation of nurses in the Philippines might not be at the same level as in the UK cannot be underestimated. The increased global demand for nurses has prompted a dramatic increase in the number of schools in the Philippines from 251 in 2003 to 470 in 2006 with a reported worsening of the quality of education (HEAD, 2006). The reason behind some of the failures to progress reported in this study might be related to different skills. Reflective practice in Britain is a relatively new approach in nursing that is taken in the Philippines in a less systematic manner.

"Our educational system is different. Here we do our reflections, this is the thing, we don't have this at home, yes you reflect but you don't have to put it in writing, no? Here we were given the reflection diary. The first time I did it; it was so hard but is better as I go along."

ID/F1.5/15.7mUK/YesOSExp

Future Plans

The future for IRNs is often uncertain. Initial planning was done based on unrealistic expectations. Most of the nurses do not have a clear idea of their plans for the future, which sometimes is the result of lack of adaptation to the new environment.

"I formatted myself to be working for four years and then if things would go alright then I could extend my contract until... until I don't know [laughter]."

ID/F1.1/15.7mUK/YesOSExp

Nurses recruited internationally by the Trust are free to leave the job before completing the contract period if they wish, but theoretically they have to pay back the Trust the cost of the courses that they have undertaken, although this policy is rarely applied as confirmed by a staff member from the HR Department in the Trust (personal communication):

"...After the adaptation I can leave at any time but I have to pay the amount of the courses or something like that. There was a list of that if you have finished so many courses, after six months you have to pay that much after one year you have to pay that much, etc. You can leave at any time."

ID/d7/7.8mUK/YesOSExp

Most of these Indian nurses said that if after the first 4 or 5 years they were happy in the UK they would stay:

"If it is okay, then I will stay forever, till my retirement, I will stay. If I can bring my family and all that, then I will stay here."

ID/d1/1dUK/NoOSExp

Different factors influenced their plans. Many of the Indian nurses said they would take decisions about their future according to their families. Children were a very important factor in the process of planning for the future as this nurse suggested:

"In Indian culture we just go for the children and they live for us, is so much family oriented basically, I think that it has to be continued. I just want them to have a good education and a good position, good life [in UK], they can decide [later] whether they want to stay or they want to go back...."

ID/d7/7.8mUK/YesOSExp

For nurses who expressed their intention to stay in the UK for the long run, economic factors were also important as this Indian nurse suggested:

"...[I plan to stay] for some time, till we have good savings, till we have a good benefit over here, so that we can go back in a later time and have a good living over there without any [nursing] work."

ID/Id4/2dUK/NoOSExp

Comparing the answers of each Indian nurse during the three interviews there was an evolution in their plans according to their ongoing experiences. One changed her plans substantially during the process of adaptation. Having initially expressed her intention to stay in the UK for a longer period, she was more circumspect at the time of the third interview:

"Now I have to think once again because here, the living is not to my standard, to my expectations..."

ID/Id2/1.5mUK/YesOSExp

Most of the Indian nurses mentioned that they would like to retire in the UK and then go back to India:

"Most probably I'll go back to India. At my retirement age I don't know if both my parents will be there or not but still my people will be there my relatives will be there..."

ID/Id3/1dUK/YesOSExp

Filipina nurses from the group that arrived four years before being interviewed mentioned that after the first four years contract they decided to stay longer. Some said that during these four years they had made different plans that still needed their financial support. They also claimed to have created expectations in their extended family members and that they could not now fail to support them:

"The buttonhole really depends on how big is the button, so that's it; you have plans for improvement for yourself and your family as well. My mom has retired so I have to finance her, although she has her pension, it is not enough, I have got my brother, I have got so many nieces! You have to finance them so that they are able to study, so If I go, if you go back home, you will end up [the support], so here we go again, we'll renew another four years and lets see how it goes."

ID/F2.1.3/46.5mUK/NoOSExp

Many Filipina nurses suggested that they underestimated the time needed to achieve their economic targets:

"I said I will work there for five years, and by that time I will already have earned lots of money, but now is my fifth year and I didn't earn enough."

ID/F2.2.4/52.1mUK/NoOSExp

Another nurse underestimated the time for adaptation and the acquired responsibilities towards her family:

"I really thought of staying for two years, because my contract was a two year's and I really thought of finishing my contract and go back home, and that's it, end of story. But by the end of two years you are really starting to like everything, starting to like your colleagues, starting to learn everything about the ward plus the fact that you know financial as well, if I go back home, where would I get the monies to support my family?"

ID/F2.2.1/55.4mUK/NoOSExp

It is surprising, given how important it was when they decided to come, that there is no mention of professional reasons to stay in the UK. All reasons reported behind the plans were either economic or personal.

When asked about where they would like to retire most nurses answered that they would like to retire to their countries of origin. However those nurses approaching retirement age mentioned that they will retire in the UK and then they will get a British pension, which will allow them a good living standard back in the Philippines:

"In NHS they said if you retire and you want to go back to your own country, the pension will go there, so it's okay."

ID/F1.3/15.7mUK/YesOSExp

Some of the nurses that have been in the UK for four years mentioned that they would like to wait at least until they get British citizenship as that will give them the opportunity to move more freely in and out of the country:

"...In four years, as I told you, maybe if I will have my [British] citizenship, I will wait for that and then maybe I will have a career break and travel."

ID/F1.3/15.7mUK/YesOSExp

Some of the Filipina nurses expressed their intention to move to the U.S. in a few years, as that was their initial plan when they came to the UK. Their long term plan is to return to the Philippines after retirement in the U.S.:

"Actually honestly, I'm planning to go to the United States but that I don't know when. I know I will finish the contract for four years but from then I can't tell you when or how long I would stay here..."
ID/F1.6/16mUK/YesOSExp

The idea of nurses coming to acquire skills in the UK and then to return to their countries to work in their previous posts and apply their new skills seems unlikely as suggested by this Indian nurse:

"I am now much more afraid to go back India and work there, I told you is more doctors oriented, and after working here we go back to follow orders, to "do this", "do that" and we may not be able to tolerate that."
ID/Id5.3/8mUK/NoOSExp

Chapter summary

This chapter has presented some of the expectations that nurses had when they came to the UK and suggested some were not met. Expectations are generated from information received during the process of recruitment and from friends, TV and relatives before departure. From an economic perspective the chapter has shown how nurses expectations of improving their economic situation was achievable but in a longer period than they initially thought. Also it appears that Indian and Filipina nurses have different expectations and plans: while Filipina nurses plan to support their families back in the Philippines, Indian nurses plan to bring their families to the UK and improve their lives here. From a professional perspective, expectations such as professional development, better standards of care or better access to resources and technology were not always met but there were other unexpected professional experiences perceived as very positive by the nurses. This includes professional autonomy, the fact that nursing care plans are based on scientific evidence rather than on practice and the better communication and greater involvement of the patient in the caring process. As part of the professional perspective the chapter has presented then how these nurses found it difficult to advance in their career. The main barriers perceived were related to low self-

esteem and self-reliance linked to poor cultural adaptation and perceived institutional discrimination.

Chapter 6: Discussion

Introduction

The UK has suffered recurrent shortages of nurses in recent decades and plugged these gaps with international recruitment. During the 60s and 70s, the NHS had to recruit internationally because of the low number of nurses graduating from schools, mainly due to the decline in UK birth rates. During the 80s and 90s the problem persisted but this time due to reduction in the number of training places from 37,000 in 1983 to 8,000 in 1997 (Withers and Snowball, 2003). Subsequently, during the last four or five years, a relative sustained growth of the nursing workforce has been seen. However because of the recent economic deficits faced by the NHS, international recruitment was limited in 2006 to senior nurses (bands 7 and above) and nurses working in specific services such as critical care, clinical radiology or operating theatres. However, the ongoing increase in the demand for nurses and the limitations in their supply are expected to generate severe shortfalls in the near future (Aiken et al., 2004) and international recruitment will have to be used again to palliate them.

In the Trust under study one third of the nurses recruited in 2000 had left the Trust after six years. Reasons behind turnover among British nurses in the NHS are relatively well known, but not among IRNs. Understanding the different factors contributing to the decision of IRNs to leave provides useful information to control turnover. Improving retention of IRNs in the NHS would contribute to ensuring an appropriate, skilful and experienced multicultural nursing workforce caring for an increasingly diverse British population and will also contribute to reducing the need for the NHS to recruit nurses from developing countries affected by acute shortages.

Plans of IRNs in regard to their intentions to stay in the UK or to move somewhere else are influenced, among other things, by their job satisfaction. This study examines two main areas that influence the job satisfaction of IRNs. On the one hand, the study informs the extent to which the expectations of IRNs when they come to the UK are met. This influences their psychological contract (Cavanagh, 1996) with the NHS and thus their satisfaction and their prospects in regard to their intention to stay or to leave. On the other hand the experiences that IRNs have during the process of adaptation in

the UK and the outcomes of that process such as their career development also influence their job satisfaction and hence their intention to remain in the UK or to move forward. As found in the literature reviewed, intention to stay or to leave is strongly related to turnover behaviour.

In order to understand how IRNs' expectations are developed this study went back to the time when the decision to emigrate was made. Factors that push them to leave their countries of origin and those attracting them to the UK gave a key to understanding what they expected from the UK. Experiences during that process and particularly the information received during the process of recruitment contributed greatly to the development of expectations. It is at this stage that the Trust can manage the information provided to the nurses being recruited and offer a realistic job preview, which is demonstrated to be, among other things, a way of avoiding premature turnover.

Nurses adapted to the UK and to the British health system are more likely to be satisfied and thus to remain in the UK longer than those who are not professionally and culturally well adjusted. However, adaptation is a process that requires strong support. This study illustrates the experiences that IRNs had during their adaptation as well as those barriers that they found during this process.

The decision to emigrate

In analysing the factors involved in the decision to emigrate we need to differentiate those factors involved in the decision leading to the initial move undertaken by many of the nurses from their country of origin to the Middle East and those factors involved in the decision to move from there to the UK.

As presented in chapter 3, push and pull factors influencing the decision of nurses involved in this study to emigrate were essentially financial, professional, social and personal. These findings validate other studies on internationally recruited nurses (Daniel et al., 2001; Omeri and Atkins, 2002; Allan and Larsen, 2003; Awases et al., 2003; Buchan, 2003; McGonagle et al., 2004; Larsen et al., 2005; Buchan et al., 2006; Kirigia et al., 2006; Smith et al., 2006).

All nurses in this research expressed their expectations of improving their economic situation. However, nurses coming from their countries of origin were more emphatic about these economic aspirations than those coming from previous migratory destinations such as Saudi Arabia.

Using Maslow's theory (see page 42) we can argue that individual's behaviour is driven by those needs perceived as the most important. Once satisfied, motivation shifts towards other needs that are then perceived as the priority. Nurses' perception of their economic needs changed, having improved their financial situation in the first migratory destination. It was then that professional, social or more personal factors became relatively stronger. In particular, those nurses who went to Saudi Arabia as a first migratory destination found that Saudi society was even more restrictive for women than their native society, and the findings suggest this contributed to their decision to move further to the UK. Economic needs were perceived as pre-eminent, rather than the need for a more liberal social environment. Once the economic needs were covered, social or personal reasons became more important. These findings corroborate Maslow's hypothesis. Having been attracted by different factors, nurses with or without previous migratory experiences may develop different expectations and hence may need different stimuli to keep them satisfied.

Nurses coming from a first migratory destination, particularly those coming from Saudi Arabia, had already been exposed to a work environment that offered highly sophisticated technology and clinical resources. Some nurses from private institutions in their countries of origin had also worked in well resourced settings. In these cases, the experience in the UK did not meet their expectations. By providing good information pre-departure about the resources that they can expect to have available this could contribute to minimize the negative impact on motivation in this regard which, as illustrated in chapter one contributes to retention.

An important element of the British nursing system and one that attracts overseas nurses to work in the NHS is its policies about professional development. The "NMC Code of Professional Conduct" states that as a Registered Nurse *"...you must keep your knowledge and skills up-to-date throughout your working life. In particular, you should take part regularly in learning activities that develop your competence and*

performance” (NMC, 2004c). Due to the lifelong nature of professional development (Jarvis, 2005) nurses coming to the UK with the primary aspiration of improving their professional skills might pursue a longer term engagement than those coming for economic reasons as a priority.

The results of this study show that most of the Filipina nurses came to the UK with economic targets that once achieved, might have made them lose interest in remaining in the UK, particularly among those who had left their families in the Philippines. A main implication is that, in general terms, unless their objectives for coming to the UK are modified, the engagement of Filipino nurses with the UK might be shorter than that of Indian nurses.

It is difficult to assess the socio-economic improvement nurses experienced by coming to the UK. There appears to be differences in this regard between the Indian and the Filipina nurses. Indian nurses, in the time covered by this study, were in the UK for too short a time to evaluate their improvements. However, they expressed dissatisfaction with living conditions, some observing a noticeable worsening in their living standards. Institutional accommodation, earning comparatively low salaries, or meeting difficulties in bringing their families to the UK, were commonly perceived problems. Keeping families together often meant the husband had to leave his employment in India and look for a job in the UK. The family had to live on the nurse’s salary until that happened which made it difficult for them to achieve improvements in their socio-economic status. Husbands often have to accept jobs below their previous standards in India. The case of Filipina nurses was different. They often lived in shared houses at a lower cost. Most of them mentioned that after one year they were attaining some of their economic goals such as paying tuition for relatives or investing in businesses back home.

In studying how the decision to emigrate is made, the personal interests of migrants are important. However social and cultural influences are also involved. In the Philippines, migration is considered not only as a professional option, but one of survival. The fact that, doctors in the Philippines are now undertaking nursing studies as an opportunity to emigrate supports that argument (Bach, 2007; Lorenzo et al., 2007).

Former colonial ties represent an important attracting factor for migrants in choosing a destination country. Indian nurses came to the UK attracted by what is perceived as the source of their nursing education. Filipina nurses, for similar reasons most often decide to migrate to the U.S. Filipina nurses in this study preferred the UK because it was easier to enter than their otherwise traditional American destination. The Philippines represented the main source of overseas nurses to the U.S. in 2005. The great flow of Filipino nurses trying to migrate to the U.S. generates great competition. From an average of 15,000 nurses taking the tests required to work as a nurse in the U.S., in 2005 only 42% of applicants passed it (Rosario, 2006). The number of visas issued by the U.S. Immigration Department for nurses is limited. Such a competitive environment may have contributed to the decision of some nurses to come to the UK as a first step before moving to the U.S. Their experience in the UK for a number of years is perceived to contribute to improving their professional value and helping them towards their final aim of entering in the U.S. nursing labour market. It was also suggested that the fact that the UK system offers longer holidays was important for this group of nurses. Having their families back in their country, they need to go back regularly, which would be difficult if they were in the U.S. where employers offer shorter holiday periods. Also the easier process of application was mentioned as one of the positive aspects of the British system.

The recruitment process

During recruitment, particularly in its initial stages, nurses have their first contact with the system. Information obtained during these first moments is important in the development of expectations. From the accounts that nurses provided in this study it can be concluded that information during the recruitment process was inaccurate and sometimes misleading. Having been requested during recruitment to look at the Trust website for the physical appearance of the Hospitals, nurses arrived in the UK expecting to find modern buildings and comfortable accommodation. Managers who went to India and the Philippines for recruitment in 2000 reported that information provided by the recruitment agency during the briefing was more akin to tourist information than to a professional briefing. Incomplete information was also provided with regard to salaries and the cost of living in London.

Recruitment officers from the Trust were not always prepared for the recruitment process. Being shocked by the level of poverty perceived in Manila or by the stories that nurses told them during the interviews, they claimed to have assumed a protective attitude towards the nurses, helping them to provide the right answers and undermining rigour in applying objective technical criteria. The inefficient screening undertaken by the recruitment agency, lack of preparation of the recruiters and their overprotecting attitude during interviews may have biased the recruitment process and affected its outcome. Although recruitment managers acknowledged the problem and explicitly suggested they had informed the Trust about it, the fact that nurses recruited during more recent missions reported similar problems indicates a lack of an effective response by the Trust to the problem.

Despite the initial decision having been made by the nurses and their families, the role that recruitment agencies play in international recruitment is important (Connel and Stilwell, 2005). They facilitate the emigration of nurses by informing about work opportunities abroad and also by supporting them with the process of recruitment. Improvements in access to information about job opportunities in less developed countries have contributed to the globalisation of the nursing labour market. Recruitment agencies play an important role in this process offering this information through different means (e.g. newspapers, Internet, etc.). However to say that recruitment agencies instigate the migration of nurses from developing to developed countries could divert the attention from the fact that it is the poor working conditions in source countries and the shortage of nurses in destination countries which make nurses decide to emigrate. Many of the nurses in this study had already decided to emigrate even before completing their basic nursing training. Sometimes Filipino families pushed nurses to undertake nursing studies as a family survival strategy sometimes even against the choice of their daughters. Facilitating the different processes leading to migration (e.g. bureaucratic procedures) is another important role played by recruitment agents abroad. In addition, recruitment agencies contact nurses in migratory destinations promoting further moves to other countries. Some of the nurses in this study that were working in Saudi Arabia were contacted and offered jobs in the UK.

British grading system and other legal requirements in the UK were major sources of frustration with many of their expectations not being met at this level. Despite some of them being very experienced, all nurses had to start their professional career in the UK at the same level as a just graduated nurse (D grade or current band 5). Sometimes nurses were not able to use some of their skills due to the fact that, even if they were able to perform some techniques, they did not have the legally required accreditation. Sometimes having access to courses to obtain those certificates was difficult, as they were in high demand. Understaffing was often mentioned as one of the reasons given by managers not to facilitate access to such courses to IRNs. Not being able to perform some of these techniques was perceived as a major source of frustration by IRNs but it also represented a major inefficiency for the system. Some factors were involved in this dilemma. On the one hand, the Trust has the obligation to ensure patient's safety and in order to do so they have strict regulations to ensure the best standards of care to all patients. On the other hand, the Trust is recruiting highly skilled and very experienced nurses who cannot apply their skills or experience in practice. Sometimes managers were not offering the level of support expected by these nurses. The implications for the efficiency of international recruitment are serious. Nurses also mentioned fears of deskilling and overall an underestimation of their skills by colleagues and managers. This is consistent with the results of other studies such as Allan and Larsen (2003) or Daniel et al. (2001). The post-registration phase is one of adjustment to the reality. Nurses, after their registration with the NMC experienced a shift in their expectations. Having seen that expectations in the professional and economic perspective were relatively unmet after some time, there was a shift on their ambitions towards more personal perspectives such as the education of their children or their relative social improvements from previous migratory experiences such as their freedom of worship or their less restrictive social environment in the UK.

The expectations of nurses with previous migratory experience differed from that of nurses with no previous experience. Nurses coming directly from their countries of origin were more likely to report their economic expectations as priority rather than other expectations. Nurses coming from Saudi Arabia or any other country, having already experienced economic improvements, reported professional and social or personal motives more emphatically. The implication is the importance of analysing the individual background of IRNs in order to understand their perspectives.

Partially met, unmet and readjusted expectations

In the literature reviewed, evidence was found that suggested employees not meeting their expectations have substantially more propensity to withdraw from their job (Kotter, 1973; Porter and Steers, 1973; Wanous et al., 1992; Phillips, 1998; Kupperschmidt, 2002). The “push and pull factors framework” of migration has helped this study to analyse factors for nurses to make the decision to emigrate. Factors attracting nurses to the UK in this study validate those found by other researchers (Daniel et al., 2001; Allan and Larsen, 2003; Withers and Snowball, 2003; McGonagle et al., 2004). These include economic, professional, social and personal motives.

However, their expectations changed gradually along the different stages in the process of adaptation. During the **pre-departure phase**, nurses developed expectations based on information provided mainly from friends and colleagues working overseas (including British colleagues) and TV or movies. However the most important information at this point was obtained during the process of recruitment. The first contact with the employer during the recruitment is essential in the development of expectations that leads to a psychological contract with the employer (Cavanagh, 1996). From interviews with recruitment managers it seems that in 2000, during the first overseas recruitment undertaken in the Philippines, the Trust was aware of the inadequacy of the information provided by the local recruitment agency involved in the screening of applicants. However the fact that nurses involved in this study recruited in 2003 and 2004 mentioned similar problems indicates that it persisted.

Nurses during their two weeks **induction programme** started to glimpse the complexity of the British health system and the disparities between that and any of their previous experiences either at home or in previous migratory destinations. During the **pre-registration phase (ONP)**, nurses found that most of their economic and professional expectations were not being met. Economically their expectations were developed based on the information received from the recruitment agency and the staff from the Trust during the recruitment process. This information was incomplete, as it did not comprise any indication of the cost of living in London or information about the fact that they should pay taxes and how much that would represent from their monthly salary. Professionally their experience of limitations in their scope for practice due to the

Thus expectations and their contribution to job satisfaction are not static. They change through the different stages of the migratory experience. In order to adjust the expectations of employee and employers and to offer the necessary support to IRNs in this regard, it is important to understand what motivates nurses to move from one country to another and what is it they expect from the new destination.

The process of adaptation

Nurses in this study went through different phases in their adaptation to the UK, which were similar to those identified by Pilette (1989) in her study and those described by Winkelman (1994) as the stages of cultural shock.

The first phase of "*acquaintance*" coincided with the period covered by the ONP in Pilette's study. Before departure from their countries of origin nurses had several contacts where they received information about the UK and which resulted being essential in the development of expectations. This study has illustrated the link between expectations and turnover/retention. Despite Pilette (1989) considering the phase of conflict resolution the most important in terms of retention outcomes, this study has shown how the first stage of overseas meeting within the phase of acquaintance plays an important role on the intention to stay or to leave of these nurses.

Nurses in the acquaintance phase in this study had a positive attitude towards the challenge that their adaptation represented and perceived positively all the means put at their disposal to cope with this important and difficult process. In Winkelman's model of culture shock, this phase coincides with his phase of "*honeymoon*" or "*tourist phase*". While in Pilette's study based in the U.S. this period lasted until the end of the adaptation programme, in the UK, this phase was shorter and more in line with Winkelman's framework in which the next phase starts within few weeks of arrival. Despite the optimistic and motivated attitudes presented during the first interview, Indian nurses, after six to eight weeks, started to present signs of frustration due to the limitations imposed on their scope of practice. Being supervised often by nurses with less experience represented a challenging experience for some of them. They were at that point entering in the second phase of "*indignation*" as describe by Pilette (1989) or

"crises or culture shock" as described by Winkelman (1994). Some of the Indian nurses, having completed their ONP in three months did not express very different perceptions during the third interview eight months after their arrival in London. Most nurses at that point reported feelings suggesting a relative aggravation of the negative attitude presented during the previous interview denoting a longer phase of *"indignation"* than the participants in Pilette's study. Nurses were aware of the disparities at a professional level but they also perceived very little advance in their integration into British society. Some of them started to suspect the existence of discrimination and double standards in the process of promotion particularly reflected in their interviews after 8 months. The programme alone is not successful in helping nurses to adapt to their new working and living environment and there is need for complementary programmes to support the adaptation.

The shift from *"indignation"* to *"conflict resolution"* was not as radical in the UK as described by Pilette (1989) in her U.S. based study. Filipina nurses interviewed after one year in the UK presented attitudes similar to those described in her *"conflict resolution"* phase with indications of successful adaptation emerging slowly. There was a sense of resignation to the limitations in their scope of practice but also a persistent feeling of frustration at not being able to use some of their skills. Most found themselves far from adapting to life in London and many still reported serious difficulties socialising with British people. As a reaction Filipina nurses tended to isolate themselves and interact only with Filipino people, normally colleagues from the same recruitment cohort. They lived together, worked together and organized their social life mostly without involving British friends or colleagues what indicates a certain degree of segregation following Berry's typology (Berry, 1997). Social isolation may lead to low motivation and depressive attitudes in some of the nurses, which have implications on the intentions of IRNs to stay or to leave.

Between the first and the fourth anniversary most nurses had advanced beyond the phase of *"conflict resolution"*. However some remained in that phase after four years of experience in the UK. Differences were identified in attitudes between those nurses still holding junior positions in the NHS and the other group of nurses who managed to progress the professional ladder. The first group seemed not to have integrated and they expressed an attitude very similar to that expressed by nurses after one year in the UK.

One even showed attitudes more in line with the phase of *"indignation"* than with that of *"conflict resolution"*. They were more aware of discrimination and, although none of the nurses themselves explicitly narrated personal experiences, they were aware of other cases. As suggested during interviews, their self-esteem was relatively poor and their ambition for progression was low. Some were already thinking of leaving the UK and moving to the U.S., and others of moving back to the Philippines. The second group of nurses who managed to progress had a different attitude more in line with Pilette's phase of *"integration"* or that of *"adaptation or resolution"* of Winkelman (1994). Despite being aware of the existence of discrimination, their experience of progression had boosted their self-esteem and they were well motivated, with positive attitudes towards the future. They had a clearer view of their future plans and were eager to continue advancing in their professional career. The relationship found between the level of adjustment shown by nurses and their career advancement may suggest that helping IRNs to adjust leads to more successful career progression. However it is difficult to ascertain a causal relationship. Nurses could be motivated due to their successful progression or they may progress due to their greater motivation as compared with the more junior group.

The applicability of both frameworks for adjustment to other settings is relative. While Winkelman suggests that the duration of the process of adjustment is very different for different people, Pilette suggested that it takes one year for IRNs to get integrated within the system in the U.S. In her model, the process is synchronized with the different elements of support that the recruitment strategy involves such as induction and orientation periods. While the sequence of phases is similar between Pilette's and this study, the time lapse from one phase to the next seems to be longer in the UK. The reason may well be that in the UK the "support package" offered by the Trust is not as comprehensive as it is in the context where Pilette's study took place (Massachusetts, USA). There, support was offered through community groups, buddy programmes, individual and group counselling services and immigrant nurses associations. Unlike in Pilette's study, where the process is linear and the sequence of phases is relatively well defined, this study found that the process of adaptation, despite of following a similar sequence of phases, was sometimes returning to previous stages, particularly when nurses were facing problems such as failing promotion interviews.

Indian and Filipina nurses responded differently to the challenges faced during the adaptation period and therefore had a different sequence of experiences. During conversations with managers and mentors they suggested that Filipino nurses were very quiet and subservient during their early adjustment and relatively different from the group of Indian nurses. Indian nurses were more in line with British attitudes, were more pro-active in their demands and outspoken with their problems. Among the Filipina nurses there was one who seemed fully integrated into the British system both socially and professionally. The fact that she had previously been living and working in an Anglophone Western country indicates that cultural distance is an important factor to take into account when planning international recruitment, as nurses progress differently depending of their original culture and their experiences.

It is important to understand how managers and mentors “labelled” IRNs as it provides information about their attitude towards them. A manager who sees IRNs exclusively as an economic migrant may underestimate their professional expectations and offer them less support than to a local nurse who may be seen as “more professional”. Development of nursing within the ward was important for some of the managers. Seeing IRNs as short-term contributors may influence their attitude towards supporting them professionally. In fact Indian nurses in this study expressed their intention to stay for the long run if they were properly treated. They came to the UK “to stay”. The expression “...*Filipino nurses are a very subservient culture...*” is a generalisation. A manager with such an attitude is more likely to assume that all Filipino nurses are subservient and lacking initiative. The manager who demonstrated stronger interest in the professional progression of IRNs was one who was an overseas nurse herself. Improving the perceptions about IRNs by managers may improve their attitudes towards them and their support for career progression.

The Overseas Nurses Programme (ONP) is one of the main strategies supported by the NMC to support adaptation of IRNs and ensure their appropriate integration in the British system. From the two components of the ONP, the protected learning was perceived positively while there were more problems with the supervised practice. Nurses had the protected learning phase at the beginning of their ONP when they had no practical experience about the system yet. It was understandable that the Trust needed to ensure a minimum package of knowledge for these nurses to start operating safely in the

wards but coordinating theoretical and practical learning along the whole ONP may have proved more effective than the current programme. Nurses in this study, despite having long professional experience, sometimes underestimated the issue of patient protection. The Trust has a duty to protect patients and ensure nurses are competent before they can be allowed to practise independently.

Perceptions about the effectiveness of the ONP were mixed. On the one hand, some nurses involved in this study perceived it as limited in achieving its objectives. However, there was a sense of ignorance about the aims and objectives of the ONP, with the programme seen primarily as an assessment period in which they had to demonstrate their nursing abilities. On the other hand, only a few of the participants spoke about issues such as the legal or ethical aspects of nursing that the programme promoted. This lack of understanding may have contributed to some of the conflict between the Trust and some of the nurses when they were denied the professional level for which they had been recruited in India. In their countries of origin, nurses work in a context of subordination to doctors, who are accountable if something goes wrong. Trying to open the perspective of nurses coming from such systems during a 20-day course seems ambitious and it took time in the wards for nurses to appreciate the implications of holding broader ethical and legal responsibilities derived from their professional practice. Some of the nurses found the ONP inadequate for assessing their capabilities, limited largely to too basic technical abilities for the level of specialization of the services where they were assigned. However, this is maybe due to the fact that the scope of the ONP is broader than what nurses understood and while they focus on their technical abilities the programme looks for a broader nursing perspective. Some of the mentors interviewed for this study did not give a sense of full understanding of the broadness of the programme.

The Trust policy to recruit in groups was perceived as positive by IRNs. Support during the trip from India or the Philippines and during first weeks in the UK is important for IRNs as they face one of the most stressful times of their migratory experience. The group of Filipina nurses with one and a half years experience in the UK reported being satisfied with the support received by the overall mentor assigned by the Trust to their cohort. However, due to financial constraints, the Trust did not replicate the strategy with further cohorts of overseas recruits.

Adjusting to professional disparities between their country of origin and the UK represented an important element in the process of adaptation. Nurses in this study had to go through a process of readjustment of their professional identity. As suggested by Stenbock-Hult (1985) in Ohlen and Segesten (1998) professional identity is the individual nurse's perception of her/himself in the context of nursing practice (Ohlen and Segesten, 1998). Self-image is an important element of professional identity. From a professional perspective there were important differences in how IRNs saw themselves as nurses and how they saw UK nurses. Again we need to differentiate between Indian and Filipina nurses. Indian nurses, having been educated based on a patient-oriented approach more in line with British nursing, were closer to the UK nursing professional identity. Filipina nurses, however, being used to a more task-oriented model, more in line with the American system, had a different image of nursing. Both Filipina and Indian nurses strongly identified themselves with their technical skills. When they spoke about nursing, they often referred to their technical abilities or the techniques that they were able to perform as an essential element of their professional identity. Their ability to apply complex techniques was mentioned as an attribute of a good nurse. When they said that nursing was the same everywhere, they referred to those techniques, rather than to a more holistic concept of nursing, mentioned by their British nurse managers and mentors who had the patient and her/his care as a central element of their nurses' identity. However when they referred to other areas of nursing such as "primary care" they recognized that nursing was different in the UK. In some cases they did not feel those tasks should be attributed to nurses but rather to non-qualified carers or to patient's relatives as it often is in the Philippines. That may have explained the strong frustration that nurses in this study expressed for not being allowed to apply certain techniques and the emphasis that they put on being able to be assessed during the ONP based on their technical abilities rather than on a more holistic professional approach. This different conceptualisation of nursing contributed to a perceived underestimation of IRNs' skills and abilities by UK nurses and managers.

In the process of re-adjustment of professional identity that IRNs have to go through when they come to the UK, the image that British peers and managers have of them contributed to the development of their own self-image. Some managers saw IRNs as a short-term solution to the problem of nursing shortages. IRNs may be receiving less

support for career advancement from those managers than other nurses who are perceived as planning to stay longer in the system and therefore deserving more support for professional development.

Nurses in this study attributed an important role to the uniform as a symbol of their profession. However this was mentioned more often by Filipina than by Indian nurses. Nurses back home were used to wear their uniform out of the hospital after finishing their shift, which is not allowed in the UK, mainly due to infection-control policies. The implication is that nurses in India and the Philippines are nurses beyond the working time while in the UK nurses, once they finish their shift they become “normal” citizens and their professional identity is not carried out beyond the boundaries of the hospital. The fact that Filipina nurses were more likely to mention this may be caused by the greater social recognition of nurses in the Philippines than in India, where nursing is sometimes not considered as a “clean” profession. The frustration reported by nurses generated by this represent another element to be considered in the adjustment IRNs to the British professional environment.

Overseas nurses associations represent a strong social network for IRNs and an excellent support during the adaptation process. The Philippine Nurses Association of America (PNAA) has been supporting nurses in the U.S. for the last three decades (PNAA, 2007). They provide professional and personal support to their members, promote contact among them and advocate for their rights. Similar associations are now being established in the UK. The Philippine Nurses Association of United Kingdom was founded in November 2004. Filipina nurses in this study were not yet aware of its existence.

Among the strategies that IRNs adopt to cope with problems with cultural adaptation, withdrawal and minimisation of contact with the British culture is one with serious consequences in terms of isolation. Support is sought often from nurses from the same recruitment cohort but rarely from British colleagues. They also increase contact with their families back home. As a reaction to the uncertainty created by the adaptation process, nurses often prefer to plan for short periods rather than strategically.

Professional adaptation cannot be separated from cultural integration. In the U.S. they have specific programmes to help IRNs to adapt to their new environment. In South Nassau Communities Hospital in New York they instituted a buddy programme by which one experienced nurse, often from the same cultural background of the new nurse, is assigned on a voluntary basis to assist the new internationally recruited nurse during the first weeks in the country (Ryan, 2003). The programme, which has proved to be very successful in helping new overseas nurses to adapt, is just one element of a whole cultural diversity programme (Kinsley, 2007). Some of the managers in this study had the view that IRNs deserve the same support than any other new nurses joining the system, ignoring the specific circumstances which IRNs face while trying to adapt. The barriers to adaptation identified in this study validate those found by other scholars in other studies (Yahes and Dunn, 1996; Yi and Jezewski, 2000; Daniel et al., 2001; Allan and Larsen, 2003; Choy, 2003; George, 2005; Smith et al., 2006). These were related to communication issues, professional and cultural disparities and discrimination.

Career progression

There were expectations from both employers and employees about the career progression of nurses recruited internationally by the Trust. Senior managers expected internationally recruited nurses to progress at a similar pace as local nurses. Indeed, nurses involved in this study reported professional development as one of the attracting factors to work in the UK. However the reality was that many of the IRNs were not progressing as expected, which was, as reported by the Trust, causing problems of imbalance in the nursing workforce leading to an increased need to recruit senior agency staff, with important financial and professional implications.

This study has presented evidence that those nurses who managed to progress in their careers showed indications of better adaptation to the UK environment. Their attitude during the interviews, their active participation in the conversation and even the language they used was quite different from those who were stagnating at lower levels or those who had decided not to pursue professional advancement. However, some individual factors might have had some influence. The more advanced group comprised younger and relatively less experienced nurses than those in the other group. Younger and less experienced nurses are more flexible and keener on accepting the role of a junior professional in need of learning and progressing than those nurses with more

experience who have gone through a process of professional demotion since their arrival in the UK. However, as mentioned above, due to the study design, the causal relationship is difficult to establish.

The important influence of nurse managers on their subordinates' career was evidenced when all those nurses with one and a half years of UK experience working under the same management decided not to pursue advancement. Lack of support from managers was reported. Some of the reasons behind this lack of support were the fact that some managers did not understand the special needs of IRNs, together with other problems such as the shortage of staff and the great proportion of agency staff in some of the wards.

Poor self-confidence was pointed out as a main problem by one of the two overseas nurse managers interviewed who was from overseas. Having experienced herself the difficulties of an overseas nurse in getting adapted and having succeeded in progressing within the system as a "foreigner", she was now offering extra support to overseas nurses. She mentioned not only offering them opportunities for personal development such as courses, but also helping them in developing attitudes that helped them to consolidate their self-confidence and also to perceive that they were valued. However, this positive discrimination could create resentment among British nurses.

While Smith et al. (2006) found that discrimination in promotion was mainly based on race and ethnic origin in their study, this study also suggests that there was discrimination against white nurses from non English-speaking backgrounds (e.g. Spanish). This suggests that discriminatory behaviour affects nurses with limitations in their communication either due to poor language skills or due to cultural attitudes.

The implications of the evidence from this study of bullying and discrimination on the process of adaptation of overseas nurses to the UK environment are diverse. Adverse attitudes and behaviours may affect nurses' self-esteem negatively (Randel, 2003). Low self-esteem and poor self-perception could be linked with the passive attitude of some of the nurses in this study in regard to career progression. Underreporting of bullying and discrimination is more frequent among nurses from black and minority ethnic groups (RCN, 2006). Accepting or reporting to the researcher that discrimination from

patients was the result of a racist attitude towards foreign nurses was difficult for some of the IRNs. The researcher during one of the interviews, when confided about perceived discrimination, informed the nurse about the policies of the Trust in this respect and discovered the lack of information that the nurse had in this respect.

The economic implications for IRNs of assuming positions of responsibility within the system were hindering their advancement on the professional ladder. In particular many Filipina nurses prioritised their economic targets above their professional ambitions. In the trade off between professional advancement and economic improvement many expressed being satisfied with their positions and not having any intention of assuming further responsibilities for the economic incentive offered. Others, despite reporting their reluctance to assume primary nursing tasks such as feeding or washing patients, they claimed, when asked about their priorities in this regard, that they preferred to do bed-side nursing rather than assuming positions of managerial responsibility.

Future plans

Efficiency of international recruitment relies strongly on the future plans of IRNs. On the one hand, if they plan to stay for a short period, the investment during the recruitment (e.g. flight fares, accommodation, food tokens, transport and communication) might not be compensated. On the other hand, when they leave, the opportunity cost of losing an experienced nurse from the workforce contributes negatively to its efficiency. Nurses planning to stay in the UK for a longer period contribute to increase the efficiency of international recruitment.

It was somewhat difficult to explore the plans that these nurses had due to a high level of uncertainty about their future that was often translated into short-term and ad-hoc planning. Initial plans based on expectations about the UK developed pre-departure had to be readjusted to the reality found after arrival. Most Filipina nurses had to extend their period in the UK beyond their initial plans in order to achieve their economic targets. That was partially because they assumed financial responsibilities with their families who needed a more sustained contribution or because they overestimated their earnings or underestimated the costs of living in the UK. Similarly, Indian nurses found that their financial improvements would be achieved in a longer period than initially

planned mainly due to the inaccurate and often incomplete information received pre-departure about their economic conditions and the cost of living in the UK.

Families are a strong influence on future plans. Indian nurses suggested that the benefits for their children would be major criteria for decision making as well as the opportunities for the husbands to find a satisfactory job. As suggested in other studies such as George (1998) the importance of gender and the distribution of responsibilities within families of migrant nurses represents a major influence in the decision making process.

Economic motives, among others, attract them to the UK and keep them here for a longer period than initially planned. Nurses plan unrealistic economic achievements and need to adjust their plans and extend their initial commitments. The main factors influencing the intention to stay or to leave are economic and personal. Professional motives attract overseas nurses to the UK but do not appear to be as relevant in retaining them. However this could be an artefact of the methodology of the study. The fact that the researcher is an overseas nurse himself may have offered IRNs confidence to talk as to a “friend” rather than as to a “stranger” in which case the answer may have been different.

There were differences between Filipina and Indian nurses in terms of future plans. Filipina nurses tend to plan around their economic targets. Younger nurses plan to stay in the UK until either they get the money to buy businesses back in the Philippines or until they fulfil all the necessary requirements to go to the U.S. Those near to retirement tend to express their intention to retire in the UK and then return to the Philippines. Indian nurses plan first to bring their families and then to improve their lives together in the UK.

There is currently a strong debate about managed migration as a strategy to balance the harm caused by rich countries to health systems in poor countries by actively recruiting their scarce human resources for health (WHO, 2006). The idea held by some scholars and policy makers of overseas nurses coming to the UK, learning skills and returning to apply them in their own systems (Wickramasekara, 2002; Dodani and LaPorte, 2005; Ogilve et al., 2007), seems rhetorical. In fact there is no evidence available to

substantiate this argument (Martineu et al., 2002). Some of the nurses in this study expressed concerns about the fact that being now used to working autonomously in the UK they would find it very difficult to return to a doctor-led system. Having also acquired a certain economic status it is also unlikely that nurses would go back to the situation of low salaries and unemployment, which pushed them to leave in the first place. Filipina nurses expressed their intention to go back to the Philippines but not for nursing. They planned to go back and start businesses, most of them out of the nursing profession. Thus, nurses in this study are more likely to, either stay in the UK; move to another country or to return to their countries but it is unlikely that they would return and apply their new skills there.

The study of nurse migration: implications for health systems

While trying to explore the phenomenon of migration and in particular the factors associated with the development of expectations about the destination country, it was helpful to understand how the decision to emigrate was made. By understanding which factors nurses did not like in their own countries or from previous migratory destinations, this study provides important information for decision makers in India and the Philippines about their own health systems, information that can be used to develop strategies to increase retention of highly skilled and experienced nurses such as the ones involved in this study. Similarly, information about the elements of the health system perceived by nurses as unsatisfying may identify deficiencies that require to be addressed.

Problems perceived by nurses in this study while working in their countries of origin within the scope of the health system were low salaries, lack of resources (obsolete equipment and lack of clinical material), lack of opportunities for professional development, poor recognition of the nursing profession (specific to India) and poor nursing standards. Other perceived problems out of the scope of the health system include unemployment, poverty, poor opportunities for children's education, and a constrictive social structure (specific to India) or a lack of freedom and ethnic discrimination (specific to Saudi Arabia).

In the UK, problems perceived by IRNs in this study within the scope of the health system were unfairness in the system for career progression, discrimination, poor recognition by peers and managers, fear of deskilling, underemployment and job insecurity. They also perceived problems of lack of support for adaptation, particularly in regard to problems of language and communication and support in transferring their skills to the British system. The Overseas Nurses Programme is supposed to tackle some of these issues. However, some elements of the ONP were perceived as weak such as the mentorship scheme, weak systems for assessment of professional skills and the narrow scope of the programme in not covering important aspects such as support for cultural adaptation. In order to become a mentor, nurses undertake specific training. Examining the mentorship course curriculum provided by the School of Nursing attached to the Trust (see annex 7), there is no specific mention of mentoring IRNs and no mention of diversity management or related issues. Other aspects out of the scope of the health system that were perceived as difficult by nurses were the high cost of living in London and the lack of support for social and cultural integration.

When they come to the UK Indian nurses plan to bring their families, settle and stay until their retirement. However, depending on the British labour market situation, the NHS might decide to limit the use of overseas nurses in favour of locally trained and recruited professionals. As a result of the decision made in July 2006 to limit international recruitment of nurses outside the European Union and the introduction of new regulations for the renewal of the working permits for overseas nurses working in the UK, IRNs were put in a difficult situation in regard to their job security which represents an important determinant of job satisfaction. There is evidence to suggest that people who report that they feel secure in their job are more likely to report high levels of job satisfaction (Blanchflower and Oswald, 1999). There is also evidence of the relationship between job security and work satisfaction specifically in the nursing literature (Lu et al., 2005). On the one hand the NHS is trying to improve the retention of nurses within the system but, on the other hand, they put IRNs in a situation that is likely to affect their motivation to continue working in the UK. The U.S. labour market, which is in great need of nurses, is far more aggressive in its approach to international recruitment than any other in the world. While the UK established Codes of Conduct for international recruitment, the U.S. plans to facilitate their immigration regulations for

nurses. With this situation it is likely that nurses planning to migrate will decide on going to the U.S. rather than to the UK. It is well known that migratory networks play an important role in the decision to emigrate. The size of the Diaspora in one country determines the capacity for attracting potential migrants. As presented in Chapter 1, the UK will face serious shortages of nurses in the near future. The local labour market including the European Union will not be able to satisfy the demand. International recruitment, as shown in the history of the NHS, is likely to be part of the solution. Despite the existence of a Code of Conduct for international recruitment, it is well known that nurses from countries with a shortage of nurses are still entering the system. Nurses are initially recruited by the independent sector where they undertake the Overseas Nurses Programme and get registered with the NMC and then they move to NHS (Bach, 2007). If the UK loses its attraction for potential migrant nurses from countries with bilateral agreements such as India or the Philippines, there is a risk of having to rely on other countries with severe problems of nursing shortages such as countries from sub-Saharan Africa with devastating consequences for their poorly resourced health systems.

Summary

This chapter has presented the meaning and implications of the study results. It begins with the differences between the first and subsequent migratory moves in terms of reasons to move and expectations. Economic reasons were more important in the first than in subsequent moves. It explores the problems identified during the recruitment process. The inadequacy of the information provided as well as other deficiencies in the recruitment process had important implications for the experiences of IRNs during the adaptation process. The findings illustrate that economic and professional expectations were only partially met which was perceived as frustrating and resulted in a shift from economic and professional to more personal prospects among the IRNs. The process of adaptation has then been discussed and highlights some differences found between Pilette's (1989) description of the phases towards integration and those found in this study. It is suggested this is a result of the different institutional support strategies offered by the institution where Pilette (1989) undertook her study and the Trust where this study took place. The main barriers for adaptation have been discussed, particularly in relation to the professional disparities between IRNs' country of origin and the UK,

which has implications for policy makers in the Trust with regard to the support offered for adaptation. Managers and mentors were identified as key potential actors in supporting adaptation and career progression. Awareness by managers about the importance of their supportive role in IRNs' career progression and the need for them to understand their specific needs was found essential for their attitude towards IRNs' integration and retention. Bullying and discrimination were found to be an important barrier for both, adaptation and career progression. Finally nurses' initial future plans were adapted to their current experiences, which have implications in terms of retention. The chapter closes with a discussion about the importance of the study of nurse migration as a means to reflect on the British health system, particularly its weaknesses in international recruitment.

Chapter 7: Conclusions and Recommendations

International recruitment of nurses has been used and is likely to be used again in the future by the NHS to address the shortage of nurses. Nurses come to work in the UK for multiple reasons and not exclusively for economic motives. They also expect professional, social and personal improvements. This study found Indian nurses came to the UK with their families to settle while Filipino nurses came to help their families and improve their future socio-economic situation back in the Philippines. Some of them reportedly came to the UK as a step towards migration to the US and others came looking for a retirement pension. While some expectations were not met they reported unexpected experiences that were perceived positively. Adaptation to a new environment is difficult. Nurses in this study perceived that they did not receive enough support for adaptation. There is evidence suggesting that nurses recruited internationally do not stay in the UK for long (Buchan and O'May 1999; Buchan, Jobanputra et al. 2005; Thomas 2006). Frustration due to unmet expectations and poor adaptation to the UK led to low job satisfaction which is proven to increase the likelihood of turnover intentions and subsequently turnover behaviour (Kotter 1973; Porter and Steers 1973; Guest 2004). In order to improve the experience of Internationally Recruited Nurses and contribute to improve their retention, some recommendations are given below based on the findings of this study.

Conclusions about the study

The aims and objectives

The study was successful in meeting the established aims and objectives of the research. Regarding the overall purpose it has contributed to increase the understanding of the phenomenon of nurse migration particularly the recruitment and retention of overseas nurses. All objectives were also achieved. First the study explored the individual reasons that nurses have to decide to emigrate validating results from other studies and adding evidence to the existing knowledge about the importance that social and cultural factors have in the decision-making process. The experiences that IRNs reported have shed light on the process of recruitment and adaptation and have helped to identify some

deficiencies with important implications for their retention. Having explored what nurses initially expected from their UK experience and contrasting these expectations with their current experiences, the study has identified sources of frustration potentially important for their job satisfaction and thus for their retention. The study showed also how these expectations changed over the process of adaptation. It was able as well to shed some light on the specific problem reported by the Trust about the career stagnation of Filipino nurses. Understanding the plans of IRNs was difficult to assess as nurses in this study tended to look to the future within a short time horizon. However it was possible to understand that initial plans based on initial expectations change along the process of adaptation and get readjusted to the reality found. Finally, the study was able to provide recommendations based on the evidence found.

The theoretical approach

The theoretical framework was helpful in explaining and locating the different areas of the study in a theoretical perspective and hence in attaining the research aims and objectives. Firstly Van Hear's (1989) model helped to explain how the decision to emigrate was made. Secondly Winkelman's (1994) and Pilette's (1989) models both helped in conceptualising the process of adaptation. Finally organizational theories about job satisfaction such as Maslow (1987), the psychological contract and the phenomenon of turnover (Cavanagh 1996; Mueller and Price 1990) helped in conceptualising the link between the two first elements and turnover and retention.

The study showed that, as suggested by Van Hear (1998), looking to the phenomenon of nurse migration from a broad perspective contributed to an understanding of the complex interaction between individual and contextual influences that led to the decision to emigrate. For example, looking only at elements of push and pull theory would have explained only how the decision was made at an individual level, but would have neglected social influences such as the family or migratory networks and cultural influences such as religion, history or gender that also influence the decision of IRNs – as found in this study. Winkelman's (1994) study of culture shock helped to locate the adaptation process within an acculturation perspective, while Pilette's (1989) model helped to bring Winkelman's (1994) model of adaptation closer to the nursing professional reality and to explain the process of adaptation to the new work

environment. Her framework was helpful in guiding the design and analysis of this case study. However, there were some differences between her results and those of this study. Despite the sequence of phases being similar in both studies, it was found that in the UK they cover different periods of time. Another conclusion of this study is that the process in the UK is not linear; while in Pilette's (1989) study nurses apparently advanced progressively towards integration, IRNs in this study, having advanced towards the integration phase, sometimes returned to earlier stages suggesting a more irregular process. Also, the phases in this study do not appear as clearly demarcated as those described by Pilette (1989). Using Winkelman's (1994) model in tandem with Pilette's (1989) framework was helpful in producing policy-oriented evidence and avoided a purely acculturation perspective which is considered to put the burden of adaptation on the IRNs rather than on the institutions. It is therefore recommended for future studies in this area to use both perspectives simultaneously. Theories of job satisfaction such as Maslow (1987) and other organizational concepts such as the psychological contract (Cavanagh 1996) have helped to link the decision to emigrate, the expectations and the experiences during the process of adaptation with turnover and retention. They also helped in understanding the importance that fulfilment of expectations had on the experiences of the nurses and how that was related to their future plans. The use of organizational theories supported producing evidence for policy making aiming to improve the experience of IRNs and their contribution to Nursing in the Trust, which constitutes the main aim of this study.

The methodology and methods

The qualitative methods used for this research allowed for an in depth exploration of the issue which would not have been possible using quantitative methods such as surveys or questionnaires. Nevertheless quantitative data were used to frame the problem of shortage of nurses and to put the situation in a national and international perspective.

Having used a group of IRNs working in an Acute Trust in London as the case study, this research concentrated on their experiences. However, looking also at different institutional elements such as the Overseas Nurses' Programme (ONP) has contributed to reflect on how the experiences of these nurses were influenced by the employer and has provided a solid ground for policy recommendations.

Many of the studies available about the motives to emigrate of overseas nurses are based on data gathered using focus groups (Daniel, Chamberlain et al. 2001; Allan, Larsen et al. 2004; Larsen, Allan et al. 2005). However some of the reasons suggested by nurses in the current study may have been perceived as too sensitive to be disclosed in front of other colleagues and in front of managers. One of the strengths of the study lies in the fact that using face to face interviews to collect data has produced rich accounts that would not have been obtained by other ethnographic methods such as group interviews. Having used semi-structured interviews instead of more structured interview methods ensured an exploration of the areas identified in the literature review as essential, and ensured the achievement of the aims and objectives of the study.

The purposive sampling used to select the participants was found to be helpful in exploring the changes in expectations, the experiences during the process of adaptation, their plans and the perceived barriers for career advancement experienced by participants. Having chosen nurses with different lengths of experience in the UK, nurses with different migratory backgrounds and nurses from two different nationalities helped to answer the research questions. However the comparability between Indian and Filipino nurses was less than initially expected and may have limited the possibilities to explore on the one hand the process of early adaptation of Filipino nurses and on the other hand the later stages of the process among the Indian nurses. Nevertheless by presenting the experiences of both groups the study illustrates well the different stages in the process and the differences between these two migrant groups.

The few studies available in the literature examining the extent of fulfilment of the expectations of IRNs covered a relatively limited time span. The study by Daniel et al. (2001), involving nurses with less than four months of UK experience was unable to conclude whether their expectations were met or not. Similarly the study by Withers et al. (2003) involved nurses with an average of just seven months of UK experience. A strength of the current study is that it has a time horizon longer than just the first months. Involving nurses with a range of UK experience from just one day to nurses with more than four years of UK experience allowed for exploration of changes in expectations along the process of adaptation.

Using a framework approach to analysis helped in obtaining policy-oriented results particularly ensuring that the integrity of the accounts of individual nurses was preserved which facilitated the exploration of the process of adaptation and the changes in expectations and plans of the IRNs involved.

Potential limitations

Regarding potential limitations of the study it is important to analyse the generalisability of the findings. Being a case study, limited to the accounts from a group of nurses in a given context (NHS Acute Trust in London), the findings refer specifically to these nurses. However, the principles constructed from these accounts, such as the importance of the different “nursing roles” and the notions of status in the process of adaptation can be generalised to those elaborated from findings in other studies such as Allan and Larsen (2003) or Smith et al. (2006). Another potential limitation of the study could come from the limitations around the selection of participants due to R&D regulations in the Trust. The Trust may have been interested in presenting a good image regarding good practice in international recruitment and selected the participants accordingly. However, within the Filipino groups, the fact that the researcher was able to provide clear criteria for the selection of potential candidates contributed to overcome this potential problem. With the Indian group he had access to all the nurses comprised in the cohort being recruited, which gave him the freedom to select those who filled his own research criteria. Also the fact that the Trust was interested in understanding the reasons behind the career stagnation of some of the Filipino nurses surely contributed to overcome this problem. The gender composition of the sample with all the nurses being women and the researcher being a man may have had potentially limited the study. However, the fact that the researcher is a nurse himself and the long engagement with the participants involved in the longitudinal element of this research are likely to have compensated for this potential limitation.

Recommendations

The findings of this study can be used by the specific Trust under study and by the NIS in general to improve the professional and overall experiences of nurses actively recruited abroad. This may result in fairer treatment and improved retention of this

specific group. This information, in the hands of policy makers, could improve the support for the adaptation of IRNs leading to their improved performance and productivity, quite apart from a more satisfactory experience for the nurses. The skills and experiences that IRNs bring to the Trust and the NHS constitute a great asset, which could be used to improve the system. The recommendations revolve, in general, around the different areas explored and also around the specific problem reported by the Trust - the slow career progression of the Filipino group of nurses. These recommendations, despite being based on the findings of a case study, following the concept of "fittingness" defined by Lincoln and Guba (1985), and may be applicable to similar contexts such as other Trusts in London recruiting nurses in India and the Philippines.

To the Trust

Recruitment process

Findings of this study suggest three deficiencies in the recruitment process. First, weak pre-selection undertaken by the recruitment agency; second, problems during the interviews originating in a lack of knowledge by Trust recruitment managers about specific socio-economic, cultural and professional aspects from India and the Philippines, leading to an overprotective attitude during the interview process; and third, provision of incomplete, inaccurate and sometimes misleading information during the recruitment process by both Trust and recruitment agency staff.

In order to tackle these problems, the Trust should assume a more central role in the recruitment process. Working in close collaboration with the recruitment agency should involve more Trust participation during the pre-selection of nurses for interview ensuring that those selected fulfil the criteria established by the Trust. The Trust should also ensure that information about the UK and the Trust provided during the first contacts with the nurses is accurate and realistic, in order to contribute to develop and manage more realistic expectations about work and life in the UK. A more realistic job preview could improve the development of a more realistic psychological contract leading, as shown in the literature review, to a more satisfactory working experience and organizational commitment, and therefore, increased retention. Specific preparation for overseas recruitment should be provided to nurse managers travelling abroad for

recruitment. The findings of this study suggest this programme should include issues such as the different approaches to nursing in each country or the cultural differences affecting communication. The use of local interviewers in collaboration with the Trust recruitment managers could improve the interviews outcomes. The Trust, having been recruiting overseas for a relatively long period, now has a number of senior nurse managers of overseas origin. Involvement of senior nurse managers with a similar socio-cultural background to the country of recruitment could surely help to improve this process.

Support for adaptation: the Overseas Nurses Programme (ONP)

The process of adaptation, as shown in Chapters 4 and 6, follows a sequence of phases. The experiences of IRNs in each phase are different and so are the specific needs for support at each stage. Support offered by the Trust during the adaptation process was perceived in this study as poor. Findings suggest that nurse managers, particularly at ward level, play an important role in supporting nurses to adapt and progress in their careers as suggested by some of the IRNs and one of the managers of an overseas origin herself. However the managers of British origin seemed not to be well aware of this important task. Training ward managers in identifying the different phases of the adaptation process could help them plan an adequate support strategy for IRNs and offer the support required in each of the phases of the process. In order to offer adequate support, it is important that nurse managers are aware of the specific difficulties that IRNs face in adjusting as compared to any other new nurse in the ward.

Mentorship was perceived as a key element of the ONP. However there were some problems identified. Mentors felt that they were not well prepared for the specific task of supporting IRNs. Mentorship training programmes should include elements of diversity management and mentorship of experienced overseas nurses. Some problems with the organization of the mentorship scheme were also identified. Nurse managers and mentors should try to maximize the amount of contact time between mentor and mentee as well as ensure an appropriate monitoring of the progress towards the objectives of the ONP. Having had a very positive experience with the assignment of one overall mentor to one of the cohorts included in this study, the experience should be replicated in the future. Analysing the benefits of having better adapted nurses and the cost may prove cost-effective for the Trust.

Nurses perceived the 20 days protected learning element of the ONP as very positive. However, only 10 days were of group work while the other 10 were individual work that IRNs felt to be too short. Some managers found that IRNs had difficulties in reflecting on their practical experience and similarly in applying theory to their daily professional practice. Nurses coming from India and the Philippines are not used to a reflective practice. Tackling this problem within only 20 days seems too ambitious. Extending the learning element to the whole period covered by the ONP could help IRNs to increase their capacity to contrast and improve their practical skills with theoretical knowledge supporting their adaptation to a more evidence-based nursing. The same applies to the induction programme. Some of the information provided during the induction, such as ethics or legal implications of nursing in the UK, was not assimilated due mainly to the overwhelming programme and the great amount of stimuli experienced by IRNs during this early phase of the adaptation process. Revisiting these important areas again during the protected learning after some months of practical experience in the wards may help nurses to understand their importance and assimilate them to their professional practice.

Problems with language and communication were identified as an important barrier for adaptation. In order to address this problem, the ONP should be complemented with specific elements aimed at improving these aspects. In Scotland language training for IRNs was developed and implemented, oriented not only to teach English but also to promote understanding of local accents and jargons through problem-based teaching. The training reportedly offered good results among the overseas workforce with relatively quicker adaptation (Jackson 2006).

In order to offer support in the areas where nurses find more difficulties in adapting, managers should be aware of the main barriers identified in this study, particularly those in the professional environment. Understanding the disparities such as the differences in the nursing roles, professional identity, the organization of nursing care and the relationships at work, they will be able to offer more appropriate support.

IRNs suggested that British colleagues assumed a distant and disengaged attitude towards them. Sensitisation of local nurses about the advantages of having a

multicultural workforce and how they can support adaptation of IRNs could be promoted through educational sessions, workshops or similar activities.

IRNs reported being frustrated with the limitations in their scope for professional practice due, among other reasons, to the lack of accreditation to use some skills that they already had. Access to courses leading to these accreditations is often difficult due to shortage of staff in the wards and the limited number of places available. A fast-track system should be established to allow these nurses to obtain the required accreditation and be able to ratify and transfer these skills to their new jobs. This could contribute not only on improving their performance in the wards but also in building their self-confidence.

But adaptation involves also aspects that are beyond the professional practice such as everyday activities. Using public transport or finding worship venues were some of those issues suggested by IRNs in this study. Other countries have successfully established buddy programmes with the main objective of orientating new overseas nurses about these kind of issues (Ryan 2003). The Trust in this study could implement similar plans to support IRNs' initial adaptation to life in London. Overseas nurses associations in the UK could play an important role in this regard. The UK Filipino Nurses Association (PNAUK) was being established when this study took place. The Trust should contact them and request their help in supporting Filipino nurses newly recruited (www.pnauk.org.uk).

Career progression

Nurses in this study had different backgrounds, experiences and objectives in regard to their career advancement. As shown in the literature review, attainment of professional expectations strengthens the psychological contract between employer and employee and improves retention. There is no common career plan that could satisfy all the nurses, not even all those coming from one country or recruited in the same cohort. Personalized career plans should be tailored according to each nurse's background and professional aspirations from the arrival and their implementation monitored throughout the process of adaptation.

Some nurses in this study perceived that decisions about professional promotion were discriminatory and arbitrary. The establishment of “promotion committees” including senior nurses from Black and Ethnic Minorities (BEMs) could increase objectivity in the process and contribute to a fairer treatment for nurses from those minorities. Nurses failing in promotion interviews were feeling low self-confidence, which contributed to their career stagnation. The Trust should establish a system by which each failure is analysed by nurse managers in collaboration with the “promotion committees”, which could also add objectivity to the process. Some of the IRNs and managers reported problems of attitude during the interviews. IRNs should be offered specific training to build their interview skills.

To the National Health Service

As seen in this and other similar studies, discrimination is perceived to be one of the barriers for adaptation and a main reason contributing to the career stagnation of IRNs from BEMs. NHS policy should ensure that all institutions enforce, monitor and maintain a zero tolerance policy towards discrimination. Nurses in this study were not aware of their rights in this regard. The NHS should ensure that Trusts include information about existing anti-discrimination policies, the processes to report cases of discrimination, bullying or harassments and all the resources available in this regard in their ONP and induction programmes.

This study of nurse migration has proved to be an important source of information about the British NHS. IRNs in this study had different points of view about the health system in the UK. The NHS could greatly benefit of their international perspective. Organization of focus groups or action learning sets with this aim could be a good strategy to extract this knowledge and use it to improve the system.

To the Nursing and Midwifery Council

Some inconsistencies were found in information provided in official reports particularly in regard to overseas nurses. Countries reported to have contributed to the UK nursing workforce one year do not appear in reports from subsequent years what makes difficult to track changes in the patterns of immigration from different countries and for instance

to analyse the impact of the DoH's Code of Conduct for International Recruitment. The researcher faced problems in obtaining information from the NMC Registry about re-registration of overseas nurses. A first request was rejected due to alleged overwhelming workload of the Registry staff: *"Our IT people are up to their eyes in internal stuff. Asking them to undertake a complex piece of programming to produce a new data set might be a request too far"* (E-mail received on 15/02/2005). A second request made under the Freedom of Information Request Act, 2000 was rejected due to the high cost of the procedure: *"the calculated cost to comply with your request would exceed the maximum limit of £450 (section 12 (1) of the Freedom of Information Act 2000)"* (E-mail received on 05/08/2005). The NMC should strengthen its capacity to provide timely and accurate information to the public about IRNs

To the overseas nurses' associations

Overseas nurses' professional associations in the UK should assume a more pro-active role. Establishing contacts in each Trust or making information more available for new IRNs to contact them could ease the process of adaptation, particularly in the first stages of the overseas experience. They could also play an important role in the fight against racism and discrimination in NHS.

To health systems in India and Philippines

The study involved nurses with great experience that were holding positions of leadership back in their countries of origin. Brain drain of these nurses represents an important problem for the health systems in India and the Philippines. There are limited possibilities for low-income countries to develop effective financial incentives to retain all nurses willing to emigrate. However, targeting specifically experienced nurses holding positions of leadership may prove cost-effective. Having seen that these nurses looked among other things for professional improvement subsidised postgraduate training in the UK on areas such as management and research could greatly contribute to increase nursing leadership in these countries and could be a good incentive for retention.

Recommendations for further research

Lack of recognition, poor support and discrimination towards IRNs from managers and colleagues were identified in this study as barriers for adaptation and a source of frustration often leading to isolation. Increasing understanding of the attitude and perceptions of British nurses and managers in regard to IRNs could illuminate this problem and provide evidence for policy making in this regard.

This study showed that experiences of IRNs pre-departure are essential in the development of expectations and the psychological contract with the employer. Being able to study the process of recruitment from its first stages would contribute to understand further the phenomenon and would provide evidence to identify strategies to better manage these expectations. Studies could also cover nurses actually leaving the Trust and explore their reasons and their current plans for the future. All this information could improve knowledge about possible strategies to increase retention of IRNs.

India and the Philippines lose nursing leadership by exporting some of their most senior nurses. Exploring appropriate strategies to retain these nurses may prove essential in maintaining an adequate nursing workforce in these two countries. Asking senior nurses in India and the Philippines about their job satisfaction and dissatisfaction, their future plans, and whether these include going abroad, would throw light on what sort of incentives might retain them in their own countries, or at least ensure their return.

Concluding remarks on the contribution to knowledge of this study

The study, being a DrPH thesis, is policy oriented and intended to contribute to professional knowledge. As research undertaken within academic standards it has also contributed to academic knowledge about the phenomenon under study. The results of this research have validated results from other studies about IRNs. The study has also increased the general knowledge about the phenomenon of nurse migration and in particular about two specific groups. Indian and Filipino nurses come with different plans and perspectives. While Indian nurses come with their families for the long term,

Filipino nurses come with economic targets and plan to return back home as soon as they achieve these targets. One important implication is that each nurse should be considered as an individual, with specific needs and that there is no "one size fits all" approach. Expectations were partially met, and most important, expectations changed along the process of adaptation to the UK, shifting from predominantly economic and professional to more personal aspirations. The study has contributed to improve understanding of the process of adjustment to the new professional and social environment and identified areas where support is required from the employer. Unless this support is improved, IRNs do not transfer all their skills to the British environment, which undermines their contribution. Being an in-depth study based on one specific Trust this research has been able to provide policy recommendations that could be useful on improving the experience and retention of IRNs in that Trust but has also generated evidence about broader aspects which could be useful for the NHS and the health systems in India and the Philippines.

The study has also made a theoretical contribution, by using a framework based on a number of different theoretical approaches, in order to explore the multifaceted nature of nurse migration. Looking at the decision to emigrate from an individual perspective does not explain the phenomenon in its entirety. Using exclusively an acculturation perspective such as Winkelman's (1994) was also found to be inadequate by itself as it diverted the focus from an institutional perspective. Pilette's (1989) model of adaptation was tested in the UK reality, and adjusted according to the findings of the study. Using migration as well as organizational theories helped in exploring not only the decision to emigrate and the recruitment process but also the process of adaptation of IRNs. It was felt that using these different theories in tandem enriched the study.

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Annexes

- **Annex 1: Example of Research Participant Information Sheet**
- **Annex 2: Example of Research Consent Form**
- **Annex 3: Example of charts for framework analysis**
- **Annex 4: NHS Ethics Committee Letter of Approval**
- **Annex 5: NHS Trust Research and Development Office Letter of Approval**
- **Annex 6: LSHTM Research Ethics Committee Letter of Approval**
- **Annex 7: Mentorship Course Curriculum**
- **Annex 8: Overseas Nurses Programme Curriculum**
- **Annex 9: Interview Protocols**
- **Annex 10: Participants' Demographic Data**

Annex 1: Example of Research Participant Information Sheet

London School of Hygiene & Tropical

Medicine

(University of London)

Keppel Street, London, WC1E 7HT

Switchboard: 0171-636 8636 Telex 8953474



RESEARCH PARTICIPANT INFORMATION SHEET (Group A)

You are being invited to take part in a research study. Before you decide to take part or not it is important for you to understand why the research is being done, what it will involve and what you will be asked to do. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that do not understand or if you would like more information. Please take time to decide whether or not you wish to take part.

Title of the study:

Internationally Recruited Nurses: Expectations and Plans

Who is doing this research and why?

I am an international nurse myself currently involved in health research as part of my doctorate at the London School of Hygiene and Tropical Medicine. I am interested in knowing more about the experiences of overseas nurses to improve their working and living experiences in the UK. I have previous experience in interviewing people.

What is the purpose of the study?

The study will look at internationally recruited nurses working in London in regard to their experiences and future plans. The study is trying to learn more about what influences these experiences and future plans. The final objective of the study is to increase the retention of overseas nurses in the NHS.

If you agree to take part you will be interviewed on several occasions. The first interview would take place during the induction programme, not long after your arrival in the UK and then I would interview you again at different times during your first months in the UK (beginning and end of

the supervised practice programme). If you agree to take part you would be asked questions about your experiences during the recruitment process, supervised practice programme and any other experience or factor that you find important in relation to your plans for the future.

Why have you been selected and do you have to take part?

You are being asked to take part because the study is most interested in the experiences of overseas nurses working in London. Around twenty or thirty overseas nurses will be studied. In addition to nurses, ward managers and supervised practice mentors will also be interviewed.

It is up to you to decide whether or not to take part. If you decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to stop any of the interviews at any time, or leave the study completely without giving a reason. Being part of this study will not affect your work and working relations with your employer or colleagues and will not affect your status in the UK. If you decide not to take part in this study (or decide to take part and then change your mind), that will not affect your work and working relations with your employer or colleagues and will not affect your status in the UK either. You have nothing to gain and nothing to lose by deciding to take part in the study or by deciding not to take part in the study.

What will happen if you take part and what do you have to do?

If you take part in this study you will be asked to take part in three individual interviews. The interviews will be in English language.

These interviews will follow a rough outline but you will be able to discuss things that are of interest and importance to you. Each interview takes about one hour to complete. There are no right or wrong answers. You can refuse to answer any questions and you can stop the interview at any time, without giving a reason.

How will the information be collected?

With your permission, the interviews will be tape-recorded, and hand written notes may be taken. Your name will be changed on all of the materials, so that anything you say is completely private. No information used in any document related to the study will allow your identification.

During the study all interview tapes and written materials will be kept securely stored in a locked filing cabinet at the London School of Hygiene and Tropical Medicine. Once the study is over the tapes will be destroyed.

Are there disadvantages and risks because of being involved?

There are no health risks involved in the study. Becoming involved or deciding not to become involved will not affect your work, status or anything related.

Some individuals may find it difficult to talk about their lives in detail. If you find anything upsetting in an interview, you can refuse to answer or we can stop the interview. If you want to talk about something because you think is important for me to know but you prefer it not to appear in the records (tape or notes) I will stop the tape-recorder and will not take notes until you tell me to do so again. If you want to talk to someone about things raised in the interview, I can help to arrange this.

What are the possible benefits of taking part?

There are no direct benefits to taking part in this study other than talking about your working and life experiences, which you may find beneficial.

What will happen to the results of the research study?

This study will collect information on the experiences of overseas nurses working in London. The information from this study may be useful for decision makers and help them to think about ways to improve the life and working experiences of overseas nurses. The study will also be written up as part of a doctorate degree. Some sections of the research may be published later as shorter articles in academic journals. Your name or any other information that could disclose your identity will not appear in any published documents to protect your privacy.

Who has reviewed and approved the study?

This study has been reviewed and approved by a Research Ethics Committee at the London School of Hygiene and Tropical Medicine, an independent NHS Research Ethics Committee and the office of Research and Development of the xxxxxxxx NHS Trust.

Do you have any question?

Thank you very much for your attention.

Contact for further information:

Alvaro Alonso

London School of Hygiene and Tropical medicine

Public health and Policy Department; Health Policy Unit

Keppel Street, London, WC1E 7HT

alvaro.alonso@lshtm.ac.uk

Direct telephone number: xxxxxxxxxxxxxx

Annex 2: Example of Research Consent Form

London School of Hygiene & Tropical
Medicine

(University of London)

Keppel Street, London, WC1E 7HT

Switchboard: 0171-636 8636 Telex 8953474



RESEARCH CONSENT FORM

Title of Project: Internationally Recruited Nurses: Expectations and Plans

Name of the investigator: Alvaro Alonso-Garbayo

What the Consent Form means:

The consent form is to ensure that you understand what being in the study involves. This means that you agree to be part of the research voluntarily and that you understand the fact that you can refuse to answer questions or leave the study at any time.

The form is also a document confirming that I have a responsibility to protect any information that you tell me in an interview, to make sure that your privacy is protected, and respect the fact that you have the right to leave the research at any time.

Please initial box

1. I confirm that I have read and understand the information sheet dated (version) for the above study and have had the opportunity to ask questions.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time and without giving any reason

☐

3. I agree for the interview to be tape-recorded as set out in the information sheet

☐

4. I agree to take part in the above study

☐

Name of Person giving consent

Date

Signature

Researcher

Signature

Annex 3: Example of charts for framework analysis

GROUP A				
	AI (1,2 and3)	AIII (1,2 and3)	AV (1,2 and3)	AVII (1+2 and 3)
Perceived life standards worsened	<ul style="list-style-type: none">• Senior/Junior• Nice house/room• Well recognized/not• Good salary/bad• Husband good employment/not• Good school/not• Social networks/loneliness		<ul style="list-style-type: none">• Loneliness	
Barriers	<ul style="list-style-type: none">• Language• Cultural differences	<ul style="list-style-type: none">• Complex admin processes• Cost of living• Career stagnation• System ignoring existing skills (assuming they don't know)	<ul style="list-style-type: none">• Post colonial attitudes among peers• Language• Career stagnation	<ul style="list-style-type: none">• Adaptation system doesn't allow for proving proficiency• Adaptation aims too basic• Career stagnation
Expectations	<ul style="list-style-type: none">• Improved work environment• Improved economy• Professional development	<ul style="list-style-type: none">• Improved work environment• Improved peer support• Improved communication with patients	<ul style="list-style-type: none">• Improved living standards• Improved professional performance	<ul style="list-style-type: none">• Improved living standards• Improved communication with patients
Plans		<ul style="list-style-type: none">• Career progression		<ul style="list-style-type: none">• Plans depend on children's preferences
Reasons to emigrate	<ul style="list-style-type: none">• Economic• Professional development• Children's education	<ul style="list-style-type: none">• Children's education		
Frustrations	<ul style="list-style-type: none">• Accommodation• Missing family• Poor information pre-departure	<ul style="list-style-type: none">• Limited tasks/responsibilities	<ul style="list-style-type: none">• Poor information pre-departure	<ul style="list-style-type: none">• Poor peer support• Non supportive management• Discrimination/racism• Perceived unfairness• Promises not fulfilled• Poor information pre-departure• In UK what they say they don't do
Positive		<ul style="list-style-type: none">• Info to patients	<ul style="list-style-type: none">• Info to patients• Recognition by doctors	<ul style="list-style-type: none">• Info to patients• Professional autonomy• Better education for children
Differences CO/CD		<ul style="list-style-type: none">• Gender freedom• Language		<ul style="list-style-type: none">• Gender freedom

Annex 3: Example of chart for framework analysis

Recruitment process		All (1 and 2)	AIV (1)
		<ul style="list-style-type: none">• Add in newspaper• Send CV• Telephone interview with agency• Personal interview with agency• Telephone interview with hospital department in UK• Visa and work permit paperwork done in SA• 3 months for all process	<ul style="list-style-type: none">• Add in newspaper• Telephone interview with agency• Personal interview with agency
Barriers		<ul style="list-style-type: none">•	<ul style="list-style-type: none">•
Expectations	Generation-	<ul style="list-style-type: none">• Friends emigrating comments• Information from friends about the risks of working for private nursing homes as compared with working for NHS Trust	<ul style="list-style-type: none">•
	Expectations	<ul style="list-style-type: none">• Better technology (not met)• Professional development• More means to work• International environment• Team work• Good interaction with patients (better standards of care) not met• Economic expectations (not met)	
Adaptation		<ul style="list-style-type: none">• Induction overwhelming	
Plans		<ul style="list-style-type: none">• Four years and then will see• "if I'm happy I will stay"	<ul style="list-style-type: none">• Some years and then go back to establish business
Reasons to emigrate		<ul style="list-style-type: none">• Adventure (knowing other countries)• Seniors emigrating• Economic• Unemployment	<ul style="list-style-type: none">•
Frustrations		<ul style="list-style-type: none">• Disparity of shifts (12 hours too long)• Language• Expectations not met could lead to resignation• Working under supervision being a senior• Language	<ul style="list-style-type: none">• Nobody to welcome at airport
Positive		<ul style="list-style-type: none">• Promote independency among patients (self-care)	<ul style="list-style-type: none">•
Differences CO/CD		<ul style="list-style-type: none">• Freedom of movement	<ul style="list-style-type: none">•

Annex 4: NHS Research Ethics Committee Letter of Approval

XXX Medical Ethics Committee

XXX Hospital
XXXXXXX
XXXXXXX
London
XXX XXX

Telephone: XXXXXXXX
Facsimile: XXXXXXXX

Email: XXXXXXXXXXXXXXXXXXXX

04 February 2005

Mr ALVARO ALONSO-GARBAYO

RESEARCH STUDENT (Doctorate in Public Health)
LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE
KEPPEL STREET
WC1E 7HT

Dear Mr ALONSO-GARBAYO

<i>Full title of study:</i>	<i>EXPECTATIONS, EXPERIENCES AND FUTURE PLANS OF INTERNATIONALLY RECRUITED NURSES: A CASE STUDY IN ONE HOSPITAL TRUST IN LONDON</i>
<i>REC reference number:</i>	<i>05/Q0408/12</i>
<i>Protocol number:</i>	

Thank you for your letter of 02 February 2005, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair acting under delegated authority.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

The favourable opinion applies to the research sites listed on the attached form. Confirmation of approval for other sites listed in the application will be issued as soon as local assessors have confirmed that they have no objection.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type:	Version:	Dated:	Date Received:
Application		07/12/2004	07/12/2004
Investigator CV		07/12/2004	07/12/2004
Covering Letter		07/12/2004	20/12/2004
Letter from Sponsor		06/12/2004	07/12/2004
Compensation Arrangements		06/12/2004	07/12/2004
Interview Schedules/Topic Guides		07/12/2004	07/12/2004
Participant Information Sheet Group A	2	29/01/2005	04/02/2005
Participant Information Sheet Group B and C	2	04/02/2005	04/02/2005
Participant Information Sheet Group D	2	04/02/2005	04/02/2005
Participant Consent Form	2	02/02/2005	04/02/2005
Response to Request for Further Information		02/02/2005	04/02/2005
DPA(R) Form		08/12/2004	08/12/2004
Supervisor's CV		07/12/2004	07/12/2004

Management approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final management approval from the R&D Department for the relevant NHS care organisation.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Notification of other bodies

The Committee Administrator will notify the research sponsor that the study has a favourable ethical opinion.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/Q0408/12

Please quote this number on all correspondence

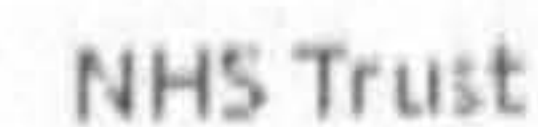
With the Committee's best wishes for the success of this project,

Yours sincerely,

Xxxx xxxxxxxxx

Chair

E-mail: xxxxxxxxxxxxxxxx



Research and Development Office

L'abb. 1. m

Ter:
EOL

RE: Expectations, experiences and future plans of internationally recruited nurses: A case study in one hospital Trust in London

Please note that all NHS and social care research is now subject to the DoH Framework for Research Governance. If you're unfamiliar with the standards contained in this document, or the policies that reinforce them, you can obtain details from the full R&G series [here](#) or from the DoH internet site. The address

As part of research governance, all investigators accessing individually identifiable personal information are required to comply with current information governance requirements. The Health Records Department will not release patient notes for research purposes unless:

- Please inform us if your project is awarded and you need to re-admin it to the LREC / MREC or if your project terminates. This is necessary to ensure that your indemnity cover is valid and also helps the office to maintain up to date records. For studies where the Trust is acting as sponsor you must send a copy of any monitoring/audit reports to the Research Governance and GCT Manager.

Yours sincerely, *Y*

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Annex 6: LSHTM Research Ethics Committee Letter of Approval

Annex 7: Mentorship Course Curriculum

LONDON SCHOOL OF HYGIENE
& TROPICAL MEDICINE

ETHICS COMMITTEE

APPROVAL FORM

Application number: 2092

Name of Principal Investigator Alvaro Alonso-Garbayo

Department Public Health and Policy

Head of Department Gill Walt

Title: Exepectations, experiences and future plans of internationally recruited nurses: A case study in one hospital trust in London

Approval of this study is granted by the Committee.

Chair T. W. Meade
Professor Tom Meade

Date 27.1.2005

Approval is dependent on local ethical approval having been received.

Any subsequent changes to the consent form must be re-submitted to the Committee.



Annex 7: Mentorship Course Curriculum

SUMMARY OF TOPICS TO BE COVERED

Week 1 Lecturer Contact	<p>Morning</p> <ul style="list-style-type: none"> Registration Introduction to module, and flexible learning material and assessments. (Need to identify own learner and Mentor in practice) Introduction to mentorship, definition of the role, aspects of the role and skills required to undertake this role. Work with study guide exploring use of Darling's Model and review Toxic mentorship. <p>Afternoon</p> <ul style="list-style-type: none"> Introduction to the concept of EBL, and examine the theory and process of EBL. Introduction to EBL scenarios. Explore the value of working through the EBL process using these to examine the use of Learning contracts, Initial meeting and negotiation of learning outcomes. 	6 hrs
Week 2	<p>Independent study using flexible learning material read / review: -</p> <ul style="list-style-type: none"> Facilitation of learning in practice – see "Placements in Focus" Mentorship / Preceptorship / Clinical supervision. Role modelling The use of learning contracts Work on EBL triggers / scenarios Work with your learner in practice. 	26 hrs
Week 3 Lecturer contact	<p>Morning</p> <ul style="list-style-type: none"> EBL workshop plus additional information for scenario. Assessing learning needs First meeting report Explore NVQ assessments / learning <p>Afternoon</p> <ul style="list-style-type: none"> Examine the learning environment concept Definition of a learning environment Characteristics, components, resources. Examine the need to audit and monitor the learning environment. 	4hrs
Week 4	<p>Independent study using flexible learning material read / review: -</p> <ul style="list-style-type: none"> Learning theories applicable to practice. Developing a curriculum, the need for clinical staff involvement – see "Placements in focus" Review Formal and Informal teaching issues. Teaching strategies Use of learning menus Revisit Darling's Model and Action activities. Work on EBL trigger Work with learner in practice. 	26 hrs
Week 5 Lecturer contact	<p>Morning</p> <ul style="list-style-type: none"> EBL workshop, plus additional information, and need to consider feedback mechanisms, and interim report. <p>Afternoon</p> <ul style="list-style-type: none"> Explore teaching and learning in practice Examine curriculum issues Examine teaching strategies, and the use of learning menus. Flexible learning opportunities – (Placements in Focus) Examine ways of working with your learner to assess their learning needs and progress. Use of questioning techniques. 	4 hrs

Annex 8: Overseas Nurses Programme Curriculum

Week 6	Independent study using flexible learning material read / review: - <ul style="list-style-type: none"> Theoretical concepts of assessment, and assessment criteria. Examine how to ensure rigor in assessment. Types of assessment. Concept of Life long learning Issues pertaining to Continuous Professional Development Continue to work with your learner and mentor in practice 	26 hrs
Week 7 Lecturer Contact	Morning <ul style="list-style-type: none"> EBL workshop, using additional information, considering decision-making mechanisms, ensuring objectivity, and awareness of level of learning required. Preparing for verbal and written feedback for final report. Afternoon <ul style="list-style-type: none"> Explore the principles of assessment and criteria The role of the student and Mentor in assessment. Activities for and process of effective assessment Feedback mechanisms 	4 hrs
Week 8 / 9	Independent study using flexible learning material read / review: - <ul style="list-style-type: none"> Issues where learning deficits are perceived Seek tutorial support Consider course assessment criteria and collation of relevant evidence Review personal professional development needs. Continue to work on EBL trigger for final report. Continue to work with learner and mentor in practice. 	50 hrs
Week 10 Lecturer Contact	Morning <ul style="list-style-type: none"> EBL workshop Presentation of findings and final report. Afternoon <ul style="list-style-type: none"> Continuing Professional Development and Education Discussion of overarching themes of Preparation for Mentorship module. Discuss areas for personal and environmental development Evaluation of the module (Nominal Group Technique) 	4 hrs

TEACHING AND LEARNING METHODS

A variety of learning-teaching strategies are used in order to meet the learning outcomes and to expose the practitioners to a range of methods. In order for students to develop their learning outcomes at the required level, the following strategies will be used at different times, and the students will work together in groups.

- Brainstorming.
- Small group sessions, presentation and feedback.
- Student directed study.
- Seminars.
- Practical teaching and assessing sessions in practice.
- Enquiry based learning.
- Critical incident analysis.

Flexible learning materials in the form of a workbook. The workbook will focus on further reading and activities in the practice area to assist students with their learning and achievement of the learning outcomes.

STRUCTURE OF MODULE

The module will be delivered through 5 study days across ten weeks.

HOURS OF PRIVATE STUDY EXPECTED

128 hours of independent study.

Annex 8: Overseas Nurses Programme Curriculum

Programme for Overseas Nurses

This programme is designed for nurses who undertook their training overseas and who wish to qualify for inclusion on the Professional Register held by the Nursing and Midwifery Council. The nature of the programme requires the Students to attend 20 day protected learning time and undertake a clinical experience period, within the hospital or independent sector, for the duration of 3 to 6 months. This is dependent on NMC approval of the individuals' previous training and some recommendation to clinical areas the length of supervised experience.

credits this programme with 30 credit points at Diploma Level (Level 2).

Structure and Organisation of Programme:

The Programme for Overseas Nurses consists of 20 protected study days and will be divided into 10 theoretical study days and 10 self directed study days utilising self directed learning packs and study hours including Employer's Induction Training Days.

The Students will gain their clinical experience of 37.5 hours per week on placement designated by NHS Trust or independent sector for a period of between 3 to 6 months. Additional study days may be organised by the Trust or the independent sector.

Programme Aims:

The programme aims to:

- Provide the opportunity for Overseas Nurses wishing to obtain registration in the U.K. to achieve competencies required by the NMC
- Enable Overseas Nurses to acquire the necessary knowledge and understanding values and attitudes and professional skills to be fit for practice as registered nurses in the U.K.

Anticipated Learning Outcomes:

By the end of the programme, Students should be able to:

- Engage in, develop and disengage from therapeutic relationships through the use of appropriate communication and interpersonal skills
- Provide a rationale for the nursing care delivered which takes account of social, cultural, spiritual, legal, political and economic influences
- Practice in accordance with an ethical and legal framework, which ensures the primacy of patient and client interest and well-being and respects confidentiality
- Contribute to public protection by creating and maintaining a safe environment of care through quality assurance and risk management strategies
- Demonstrate knowledge of effective inter professional working practices
- Manage oneself, one's practice and that of others in accordance with the NMC Code of Professional Conduct recognising one's abilities and limitations
- Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities
- Formulate and document a plan of nursing care, where possible in partnership with patients, clients, their carers and family, within a framework of informed consent
- Based on the best available evidence, apply knowledge and an appropriate repertoire of skills indicative of safe nursing practice
- Evaluate and document the outcomes of nursing and other interventions
- Create and seize opportunities to promote the health and well-being of patients, clients and groups
- Delegate duties to others, as appropriate, ensuring that they are supervised and monitored

- Enhance the professional development of self practice of others through peer support, leadership, supervision and teaching
- Demonstrate ability to practise key skills such as numeracy, literacy and problem solving
- Actively participate in discussion related to health care activities
- Practice in a fair and anti-discriminatory way, acknowledging the differences in beliefs and culture practices of individuals or groups
- Demonstrate a commitment to the needs of continuing professional development

Indicative Content

- **Work environment and local community**

Familiarisation of local facilities and amenities - social norms, health facilities
Social aspects and cultural differences of living and working in the UK
Communication differences and speech variations in UK
Nursing in UK
Empowering clients, users and carers

- **Personal effectiveness and professional development**

Essential communication and interpersonal skills in the practice setting
Teaching and learning skills
Developing and maintaining professional portfolios / profiles
Formalised reflective practice through the use of individual journals and peer action learning
Mentorship scheme and peer support
Assessment of competencies
Personal Development Plan
Reading and understanding new knowledge from articles and nursing journals

- **Healthcare in UK**

Contemporary structure and organisation of healthcare in the NHS & Independent Sector
The role of the nurse in the modern NHS & Independent Sector
Statutory and supporting roles of different nursing organisations and how they can provide individual support for practitioners but also protect the public
Strategies for promoting health and educating users of the service
Clinical governance

- **Nursing systems and structures**

Management of information and introduction to technologies
Standards for records and record keeping
Standards for the administration of medicines
Managing complaints including issues arising from professional conduct complaints
Ensuring quality healthcare in the practice setting

- **Clinical care and multi-professional team working**

Essential care skills update
Promoting an individualised and holistic approach to clinical care
Multi-professional and team working in the modern NHS & Independent Sector
Clinical area Management and Leadership skills

- **Professional Policy**

Professional Self Regulation and Clinical Governance including:

Code of Professional Conduct
The Scope of Professional Practice, Scope in Practice
Guidelines for Professional Practice
PREP and periodic registration

- **Policies and Procedures**

Fire and Fire Prevention
Manual Handling
Infection Control

- **Research**

Understanding and application
Evidence based practice and practice based evidence in the clinical setting

Teaching and Learning Strategies

Tutor-centred and student-centred methods will be used as appropriate, for example, when introducing new concepts. These will be complemented with directed reading from journals and relevant chapters from appropriate texts.

Additionally

Reflection and critical incident or situational analysis

Seminars/discussions to share varied ideas and experience amongst the programme participants

Small group work focussing on case studies / significant incidents

Debriefs to enable participants to present and defend a point of view whilst encouraging effective communication and presentation skills

Assessment of competencies:

Students will be required to complete the following:

Case Study Oral Presentation + 1,000 word write-up
Practice Based Assessment with reflections
Skills Schedule

The practice based skills schedule pack consists of core elements of technical and clinical, professional practice and behavioural skills underpinned by current theory and evidence based practice.

It is designed to enable the Students to achieve the learning outcomes stipulated by the NMC as well as the Competency Framework as directed by NHS Trust.

Each element of assessment is assessed according to the University, Trust and Independent Sector Competency Framework.

All core elements of the Practice Based Assessment must be achieved before being recommended for entry onto the NMC Professional Register.

Mentors – Facilitating Students

Definition of a mentor

According to the English National Board and the Dept of Health (DCH) 2001, a mentor denotes the role of a nurse, midwife or health visitor who facilitates learning and supervises and assesses the Student in the practice setting.

A mentor needs to be a first level practitioner having been qualified for a minimum of one year, or part time equivalent, and have successfully undertaken an appropriate recognised preparatory, certificated course.

The Students will have access to one assessing mentor and also a number of associate mentors so that at times of annual leave etc., it may be possible to work with the other mentors. These will be referred to as members of the *Mentoring Team*.

In this role an assessing mentor will need to:

- **Formally** supervise the Student in developing clinical competencies in the clinical area, and relate this to and through a learning contract;
- **Document** discussions with the Student in their assessment log; and
- **Exercise** professional judgement in relation to formative and summative assessments.

It is expected that the Assessing Mentor will undertake a minimum of **three** formal meetings with the Student during the placement.

The assessing mentor will **orientate** themselves with the learning outcomes and competencies that the student is expected to achieve during the placement.

Preparation for the clinical placement

- At the beginning of the programme, the Student will have the opportunity to discuss the assessment pack with the programme co-ordinator;
- The opportunity to devise a preliminary action plan will be available within the theoretical study days.

This subsequently forms the basis for discussion and negotiation with the mentors in the clinical practice.

During clinical placements

The Student must

- **discuss** and negotiate action plans with their mentor at the beginning of the placement;
- **discuss** and agree appropriate evidence to support the action plans;
- **arrange** regular meetings to discuss progress during the clinical allocation, and agree written comments in the final week of the allocation;
- **use** the log of discussions page to record meetings with the mentor; and
- **complete** a self assessment before the final meeting with their mentor.

Some Students may experience difficulty in achieving their learning outcomes, and competencies.

In these circumstances, the mentor should:

- **Initiate** a discussion with the Student and make a note of the discussion and any action taken on the assessment log sheet; and
- **Write** an additional learning contract with the Student to solve problem and for issues.

If the problem persists or the overall mentor feels that the Student may fail the practice-based assessment, contact should be made with the Clinical Practice Facilitator and the Programme Co-ordinator to discuss the situation.

Performance Management

It is expected that the Student and the Mentoring Team will work closely together to meet the required competencies / elements within the programme, following the initial self-assessment and agreed time-scales for achievement.

However, there may be occasions when failure to achieve the required level in an element may require further action.

In the first instance, where the Student has not achieved the required level within the agreed time-scales, the Student, their Assessing Mentor and the Clinical Practice Facilitator will meet to discuss the reasons why this has not been achieved.

Following this discussion it may be appropriate to re-negotiate the time required to achieve the required level without further action.

Where there is a particular reason this has not been achieved, all efforts should be taken to identify ways to achieve the required level, including education and training where appropriate.

If following an extension of the time-scale the Student has still not been able to achieve the required standard, a review of the element in relation to the Student's practice will be required.

Where the Student has met all other competencies / elements but has difficulty in meeting only one or two elements (assuming that in terms of agreed time-scales the programme is on target) - an extension of up to a maximum of three months may be granted to achieve the element(s) in question.

However this will only be following discussion and agreement with the assessing mentor, Clinical Practice Facilitator and may include the Director of Nursing or Senior Manager in the Independent Sector.

If by end of month five of the programme, the Student has still not achieved the competence / element, a formal meeting should be undertaken. This will involve the Student, their assessing mentor, the Clinical Practice Facilitator and maybe the Director of Nursing or his / her deputy or Senior Manager in the Independent Sector.

Notification at this time will also be given to the Student that failure to achieve may result in them not being recommended to the statutory body for registration (i.e. NMC).

Every effort will be taken to identify the reasons why the Student has not achieved the required level and further education and training opportunities will be explored to ensure achievement.

Where the Student fails to meet two or more elements at the end of six months they will be deemed not suitable for recommendation for entry to the Professional Register.

The Role of the Clinical Practice Facilitator

The supporting role of the Clinical Practice Facilitator is to ensure that the Student develops knowledge, skills and attitudes to provide contemporary nursing care within the modern NHS service and Independent Sector.

This can be achieved by supporting the mentors in providing advice in relation to the Programme for Overseas Nurses and conducting a competency based assessment of the Students.

They will receive regular feedback from the mentoring team about their Student's performance.

Clinical Practice Facilitators will normally have a group of nurses for whom they have responsibility and can be contacted via bleep or switchboard. Details of the contact arrangements will be given to the Students.

They also oversee the assessment documentation to ensure that it is being correctly completed at the appropriate time.

Expectation of the Students

The following values are essential components of practice, although there are many ways in which values can be demonstrated.

The following are a few examples:

Values	Examples of Good Practice
Respect for the individual	Always asking the patient / client how they wish to be addressed Giving the patient/client individual attention on a one to one basis and not talking through a third person (unless appropriate) Respecting an individual's culture, race, sexuality, age, religion and disability and how it impacts on their health and social care and needs
Awareness that the individual has a right to exercise choice	Acknowledges that the patient has choices Giving information when appropriate, to facilitate informed choice Can recognise when their own personal view could influence the patient's / client's choice
Maintenance of privacy and dignity	Ensuring privacy when carrying out personal care Facilitating privacy when discussing intimate or personal information Not using labels which stigmatise people e.g. not defining people by a condition/diagnosis
Maintenance of confidentiality	Understands and practices in accordance with NMC guidelines for professional practice / local policies. Is able to discuss issues in relation to confidentiality Understands and communicates to patients/clients the nurse's role in relation to confidentiality
Recognising and respecting the uniqueness and dignity of individuals, e.g. differences of race, culture, religion, sexuality, gender, disability and age.	Is able to discuss their own beliefs and values. Is able to recognise their own prejudices and assumptions and is open to being challenged by others. Has an understanding of and works in accordance with the equal opportunities policies of the practice area. Is able to discuss ways in which discrimination can be countered

In addition to the above, the Student will be expected to:

- Behave and practice in a manner, which promotes a positive image of nursing.
- Ensure achievement all of the components of the programme before application for registration can occur, and
- Liaise with the assessing mentor in order that the achievements are 'signed off' once the Student has completed them and demonstrated their competence.

The evidence sheets should be used to show evidence of progress and achievement, and can be used to highlight areas where the Student is not progressing as well as required.

- The Student will be responsible for ensuring the safety of the assessment documentation pack, as it will be important in deciding when the Student are competent to register with the NMC.

Annual Leave Entitlements for Students

During the period of clinical practice the Student may request for annual leave however this will be at the discretion of the Senior Manager. The Student, in principle, will have an allocation of annual leave days per month according to Trust/Independent Sector Policy. **However, annual leave can only be authorised by the Senior Manager.**

Each clinical area / department / home will usually have a request book, which will need to be completed as well as an approach to the Senior Manager. The annual leave year runs from April to March.

It may also be possible to request days off in the request book. Each clinical area / department / home may have their own local policy regarding the number of staff on annual leave at one time.

Should the Student require emergency annual leave or unpaid leave this must be discussed with the senior manager as soon as possible before taking the leave. Any unauthorised leave will be booked as absence and may lead to disciplinary procedures being taken against the Student.

Shift guidelines

During the clinical practice the Student will be rostered on the clinical area / home. It is advisable that a member of the mentoring team should work as often as possible with the Student. This may include working the following shifts:

Early shift:	7.5 hours
Late shift:	7.5 hours
Long Days:	11.5 hours

This internal rotation may include Weekends and Night shifts.

It is primarily important that the Student completes the required number of hours for the month. Although the Student may be requested to work night duty, it is recommended that day duty only is worked for the first few weeks to enable the Student to orientate to the practice area and to the hospital or Nursing Home.

It may be possible for a Student to be paid an enhancement for unsociable hours worked according to Trust / Independent Sector policy.

Uniform Policy

As a Student working in the NHS / Independent Sector, the Student, is required to adhere to the uniform policy whilst on duty. The Student will be wearing a staff nurse uniform during the programme (not the study days).

It is however the responsibility of the Student to inform the staff on the practice area / home of their status and will be working as a student and to work within the limitations of a student during the allocation. Name badges / hospital or Independent Sector ID need to be worn at all times.

Sickness Policy

The Student must report to the clinical area / home manager / assessing mentor if unable to attend work at the earliest possible time. The Student must also inform the Clinical Practice Facilitator. An approximate return date must be provided and a self certificate of sickness must be completed. The completed forms should be returned to the clinical area manager / assessing mentor. A doctor's certificate is required if the period of absence from the clinical area is more than seven days altogether.

Medication Policy

In some NHS Trusts / Independent Sector all nurses undertake a drug examination in order to determine the level of drug administration that they may practice at:

GROUP ONE:	Independent
GROUP TWO:	Must administer with group one or another group two
GROUP THREE:	Must only administer with an Independent nurse from group one

Annex 8: Interview protocols

Students are in Group 3 whilst on the clinical areas / homes and must accompany and be supervised by a Group 1 nurse when administering medications in the clinical area.

INTERVIEW Under no circumstances must the Student administer an intravenous drug or flush intravenous lines whilst in the clinical areas

Others

Team involvement of the Student is very important in the practice area throughout the period of Programme for Overseas Nurses. Initially the Student should be given one or two patients to care for which will ensure that they are involved in all aspects of care. This will enable the assessing mentor / associate mentors / clinical practice facilitator to see what progress the Student is making and identify any areas for further development.

All Students should be working to practice areas the standard expected of a registered nurse.

In the beginning part of the practice allocation, it is expected that the Student will work at the level of a third year student but will need considerable guidance on current practices in the UK. Basic nursing procedures should be well performed at this stage but some aspects of care and management, for example, the organisation of discharge planning, will take considerably longer for the Student to develop familiarity.

This information pack has been developed to assist the practice areas in facilitating the Student. It is hoped that practice staff will contribute to the improvement of this booklet if they feel that some information is missing or not appropriate.

For any queries please do not hesitate to contact the:

Clinical Practice Facilitators / Programme Co-ordinators

Annex 9: Interview protocols

INTERVIEW A-1 (Indian nurses upon arrival in the UK)

- How was your trip from India?
- How many years have you been working as a nurse?
- When did you decide to go to the UK?
- How was the decision made?
 - Who was involved in the decision?
 - Where did you find the information about possibilities of going to the UK?
- Why you decided to go to the UK?
 - What in your country made you take the decision to emigrate?
 - What attracted you from the UK?
- Do you have family?
- Are you planning to stay alone or will you bring your family to the UK?
- Tell me about your future plans for the coming years
 - How long are you planning to stay in the UK?
 - Where are you planning to go after the UK?
- How your career plans has evolved since you graduated as a nurse?
- How would you like your career to progress from now?
 - How do you see your career progression in the UK?
 - Would you be ready in the future to assume positions of responsibility within the nursing profession? Why/why not?
- Tell me about the overall experience of being recruited so far?
- Tell me how do you imagine your everyday life in the UK
 - What do you expect to be different from your life in India?
- Tell me how do you imagine nursing in the UK
 - What do you expect to be different working as a nurse in the UK as compared to working as a nurse in India?
- Tell me how do you imagine the NHS as an organization?
 - Tell me what you do you know about the NHS
 - Tell me how do you think NHS will be as your employer?

- Is there anything else related to this study that you would like to share with me now?

INTERVIEW A-2 (Indian nurses after three or four weeks of supervised clinical practice)

- How is everything going?
 - How do you find life in London? Is it any different from what you thought it would be? In which respect?
 - How you find now Nursing here as compared to Nursing in India? What do you like from it? What do you dislike?
 - How do you find NHS as an organization? How different is it in relation with what you thought it would be?
- Overall what has surprised you so far?
 - Overall what has been more interesting than you expected?
 - Overall what has been less interesting than you expected?
- Have your plans for the future changed since last time I spoke with you?
 - Are you still planning to stay in the UK for the same number of years you thought you would during our last interview?
 - Are you still planning to go to the same place you thought when you leave the UK?
 - Are you still planning the same in relation to assume managerial responsibilities in the future?
- What do you like most from the supervised practice so far?
 - What did you like/dislike from the induction week?
 - What about the theoretical sessions and study days?
 - And the supervised clinical practice?
- How do you think this programme could improve so far?
- Is there anything else related to this study that you would like to share with me now?

INTERVIEW A-3 (Indian nurses some weeks after the end of their supervised practice)

How is everything going?

- How is everything going?
- Tell me about your experience so far
 - How do you find your everyday life in London? How different is it in relation of how you thought it would be? Is there anything you are missing from India? How are you coping with that?
 - How do you find nursing in the UK? How different is it in relation of how you thought it would be?
 - What do you think about NHS as an organization and as your employer? How different is it in relation of how you thought it would be?
- How your or your family's living standards have improved since you came to work in London? How you expect them to improve in the future?
- Tell me about the supervised practice programme
 - How are you finding working in the wards under the supervision of a mentor?
 - Tell me the most interesting aspects of the programme
 - Tell me the most difficult parts of the programme
 - Tell me to what extent the supervised practice programme is responding to your needs in terms of support for adaptation
 - How would you improve the supervised practice programme?
 - How do you anticipate it will be when you are able to work independently?
- How long are you planning to stay in the UK?
- What are your plans in terms of career development?
- Is there anything else related to this study that you would like to share with me now?

INTERVIEW B (Filipino nurses recruited in Manila last February 2004 and working for the Trust since then)

- Tell me about your professional history
 - How many years of experience as a nurse you had back in your country?
 - What are the services or nursing areas in which you were working before leaving the Philippines?
 - Did you have any experience abroad other than Philippines before you came to the UK?
 - If so, where and for how long?
 - In which professional areas?
- Tell me about your decision to come to the UK
 - Who was involved in that decision?
 - What made you decide to leave the Philippines?
 - What attracted you to the UK?
 - Do you consider that your case is a typical one or you feel that there are some differences between you and other Filipino nurses coming to the UK?
- Tell me about your experience since you decided to leave your country until now
 - How were you feeling just before leaving Manila?
 - How were you after some weeks in the UK?
 - How were you after six months in the UK?
- Tell me about your expectations about the UK
 - How did you imagine life in the UK before you left Manila?
 - Tell me something about how these expectations about living in the UK has changed since you arrived in the UK
 - What about your expectations of nursing in the UK?
 - How they were before leaving Manila and whether they changed or not?
 - Now I would like you to tell me how did you imagine the NHS to be before leaving Manila and how that has changed until now
- Tell me about the experience so far
 - Tell me what is being interesting so far
 - Tell me what is being difficult so far

- Tell me about the supervised practice programme
 - Tell me good/difficult things of the programme
 - Tell me whether the programme did respond to your needs of support for adaptation
 - How would you improve the programme?
- Tell me about your plans
 - How long were you planning to stay in the UK before you left Manila?
And now, how longer are you planning to stay? If it changed, why?
 - If your plans changed how much do you think your recruitment and adaptation processes has had an influence over these plans?
 - Why are you planning to stay/leave?
 - Where are you planning to go after the UK?
 - What factors would make you stay in the UK permanently?
 - Have your plans for career progression changed since you arrived in the UK? If so, what has influenced these changes?
- Would you be ready in the future to assume positions of responsibility within the nursing profession? Why/why not?

Is there anything else that you would like to share?

INTERVIEW C-1 (Filipino nurses with D grade working in the UK for more than three years)

- Tell me about your professional history
 - How many years of experience as a nurse you had back in your country?
 - What are the services or nursing areas in which you were working before leaving the Philippines?
 - Did you have any experience abroad other than Philippines before you came to the UK?
 - If so, where and for how long? In which professional areas?
- Tell me about your decision to come to the UK
 - Who was involved in that decision?
 - What made you decide to leave the Philippines?
 - What attracted you to the UK?
 - Do you consider that your case is a typical one or you feel that there are some differences between you and other Filipino nurses coming to the UK?
- I would like you to tell me about your experience since you decided to leave your country until now
 - How were you feelings just before leaving Manila?
 - How were you after some weeks in the UK?
 - How were you after six months in the UK?
- Tell me about your expectations about the UK
 - How did you imagine life in the UK before you left Manila?
 - Tell me something about how these expectations about living in the UK has changed since you arrived in the UK
 - What about your expectations of nursing in the UK?
 - How they were before leaving Manila and whether they changed or not?
 - How did you imagine the NHS to be before leaving Manila and how that has changed until now
- Tell me about the experience so far
 - Tell me what is being interesting so far
 - Tell me what is being difficult so far
- Tell me about your plans

- How long were you planning to stay in the UK before you left Manila?
And now, how longer are you planning to stay? If It changed, why?
 - If your plans changed how much do you think your recruitment and adaptation processes has had an influence over these plans?
 - Why are you planning to stay/leave?
 - Where are you planning to go after the UK?
 - What factors would make you stay in the UK permanently?
- Did you ever have positions of managerial responsibility within the nursing profession back in your country? How was that experience?
- Tell me about your plans, when you came to London, in regard to your career development
 - How your plans for career progression in the UK were when you left your country.
 - Have these plans changed since you arrived in the UK?
 - If so, why?
 - Did you ever think about assuming positions of higher responsibility within the nursing career ladder in the UK?
 - Which are the main problems you found in progressing the professional ladder?
 - Tell me about how the Trust supports your career development
 - Would you be ready in the future to accept positions of higher responsibility?
 - Why/why not?
- Is there anything else that you would like to share with me?

INTERVIEW C-2 (Filipino nurses with grade higher than D with more than three years experience in the UK)

- Tell me about your professional history
 - How many years of experience as a nurse you had back in your country?
 - What are the services or nursing areas in which you were working before leaving the Philippines?
 - Did you have any experience abroad other than Philippines before you came to the UK?
 - If so, where and for how long? In which professional areas?
- Tell me about your decision to come to the UK
 - Who was involved in that decision?
 - What made you decide to leave the Philippines?
 - What attracted you to the UK?
 - Do you consider that your case is a typical one or you feel that there are some differences between you and other Filipino nurses coming to the UK?
- I would like you to tell me about your experience since you decided to leave your country until now
 - How were you feelings just before leaving Manila?
 - How were you after some weeks in the UK?
 - How were you after six months in the UK?
- Tell me about your expectations about the UK
 - How did you imagine life in the UK before you left Manila?
 - Tell me something about how these expectations about living in the UK has changed since you arrived in the UK
 - What about your expectations of nursing in the UK?
 - How they were before leaving Manila and whether they changed or not?
 - How did you imagine the NHS to be before leaving Manila and how that has changed until now
- Tell me about the experience so far
 - Tell me what is being interesting so far
 - Tell me what is being difficult so far
- Tell me about your plans

- How long were you planning to stay in the UK before you left Manila?
And now, how longer are you planning to stay? If It changed, why?
 - If your plans changed how much do you think your recruitment and adaptation processes has had an influence over these plans?
 - Why are you planning to stay/leave?
 - Where are you planning to go after the UK?
 - What factors would make you stay in the UK permanently?
- Did you ever have positions of managerial responsibility within the nursing profession back in your country? How was that experience?
- Tell me about your plans, when you came to London, in regard to your career development
 - How your plans for career progression in the UK were when you left your country.
 - Have these plans changed since you arrived in the UK?
 - If so, why?
 - Did you ever think about assuming positions of higher responsibility within the nursing career ladder in the UK?
 - If not, what made you go for it?
 - Which are the main problems you found in progressing the professional ladder?
 - Why do you think some of your same batch colleagues have not progressed the ladder?
 - Do you plan to continue going up the ladder?
 - Why/why not?
- Is there anything else that you would like to share with me?

INTERVIEW D-1 (Ward sisters)

- Please tell me about your professional life.
 - How many years have you been working? In which services?
 - Tell me about your career progression.
- Tell me about your experience of working with IRNs
 - Since when are you working with overseas nurses?
 - What about as a nurse manager?
 - From where were the IRNs you worked with coming from?
 - Have you ever worked with Indian nurses before?
 - How is that different from working with nurses from other countries?
- What IRNs add to your ward's nursing workforce? If yes, can you tell me about some examples?
- Which from your experience are the main problems that IRNs find when they start working in the UK? What about after the adaptation course and NMC registration?
- What country in your experience is providing the best nurses? Why?
- Sometimes IRNs complain because they are considered as just graduated nurses when they start working and their experience is not taken into consideration. What do you think?
- In other countries nurses perform complex tasks (management of a ventilated patients, catheterisation, etc.) from the beginning of their professional career. When they arrive in the UK and they get into the system of Grading they are not allowed to do it. Some refer that they lose these skills. Please tell me what you think about this
 - How do you think the system could best benefit of the experience and abilities of these nurses?
- How do you think how professionals trained abroad influence British nursing practice?
- Do you believe that basic nursing standards and values are common to nurses from different cultures? Why or why not?
- How do you think the Trust could improve policy and practice regarding international recruitment of nurses?

- Tell me about your views of the ONP
 - Do you think the adaptation course is enough for IRNs to work reliably?
 - What do you think of the mentoring system?
 - How do you think the Trust could improve the adaptation of IRNs?
- Some HR managers in the Trust are worried about the fact that some of the IRNs are not willing to assume positions of managerial responsibility within the NHS nursing ladder. Do you agree with them? If yes, why do you think is like that? How do you think could be the best way to motivate them to assume managerial responsibilities?
- Is there anything else about your experience with IRNs that you would like to share?

INTERVIEW D-2 (Adaptation mentors of Indian nurses from group A)

- Since when have you been working as a mentor of overseas nurses? How many of them have you mentored so far? From which nationalities?
- Are you an IRN yourself? Tell me about your experience of being mentored during your adaptation
- Tell me about your work as a mentor of overseas nurses
 - What are the objectives of your post?
 - Tell me about your tasks and responsibilities
 - What do you like/dislike about it?
 - Do you have all the means you need to do your job as a mentor?
 - Do you think you have the skills and preparation necessary to fulfil this task appropriately?
 - Have you received any special training for that?
 - How do you think the support to the mentoring of overseas nursing could improve?
- What are the benefits, in your experience, of having overseas nurses working in the wards?
- What do you think are the main problems that IRNs find when they start working in the UK (before and after registration with NMC)
- What country in your experience is providing the best nurses for the NHS? Why?
- Do you believe that basic nursing skills and values are common to nurses from different cultures? Why or why not?
- Do you think British nursing practice is being influenced by professionals trained abroad? If so, how?
- How do you think the Trust could improve policy and practice regarding international recruitment of nurses?
- What specifically in the supervised practice programme do you think could improve the adjustment of new overseas nurses to the UK working environment?
- Is there anything else that you would like to share?

Annex 10: Participants' Demographic Data

Information gathered from the participants at the end of their interview.

	CODE	ORIGIN	GENDER	AGE	MARITAL STATUS	CHILDREN		TOTAL NURSING EXP (yrs)	PREV. OS. EXP (yrs)	GRADE	TIME IN UK	
						Y/N	At UK/ Home				Date of arrival in UK	Months in UK
1	AI	INDIA	F	48	M	Y	UK	23	0	C	Feb-05	0
2	AII	INDIA	F	27	M	N		6	2	C	Feb-05	0
3	AIII	INDIA	F	50	M	Y	UK	24	9	C	Feb-05	0
4	AIV	INDIA	F	25	M	N		4	0	C	Feb-05	0
5	AV	INDIA	F	25	M	N		6	0	C	Feb-05	0
6	AVI	INDIA	F	31	M	Y	UK	11	5	C	Feb-05	0
7	AVII	INDIA	F	42	M	Y	UK	19	18	C	Feb-05	0
8	BI	PHIL	F	31	S	N		9	3	E	Nov-03	16
9	BII	PHIL	F	45	M	Y	H	22	17	D	Nov-03	16
10	BIII	PHIL	F	38	M	N		11	5	D	Nov-03	16
11	BIV	PHIL	F	43	Other	Y	H	20	13	D	Nov-03	16
12	BV	PHIL	F	44	M	Y	UK	21	14	D	Nov-03	16
13	BVI	PHIL	F	35	S	N		12	5	D	Nov-03	16
14	CI-1	PHIL	F	38	S	N		7	0	D	Mar-01	48
15	CI-2	PHIL	F	28	S	N		6	0	D	Apr-01	47
16	CI-3	PHIL	F	35	M	Y	H	15	0	D	Apr-01	47
17	CI-4	PHIL	F	48	S	N		20	14	D	Feb-01	49
18	CII-1	PHIL	F	29	S	N		9	0	F	Aug-00	56
19	CII-2	PHIL	F	31	M	N		10	0	F	Nov-00	53
20	CII-3	PHIL	F	30	M	N		9	0	E	Nov-00	53
21	CII-4	PHIL	F	30	M	N		9	0	E	Nov-00	53
22	CII-5	PHIL	F	31	M	Y	UK	13	5	H	Nov-00	53